1993 ACTIVE MEMBERSHIP PROFILE REPORT

AMERICAN PHYSICAL THERAPY ASSOCIATION

apta

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1993 ACTIVE MEMBERSHIP PROFILE REPORT

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American Physical Therapy Association

1993 Active Membership Profile Report

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I. EXECUTIVE SUMMARY

The 1993 Membership Profile Survey Instrument, developed by the Division of Research, Analysis, and Development, in conjunction with the Department of Practice of the American Physical Therapy Association (APTA), was administered by mail to a random sample of active members of the APTA. The following were among the major findings of the research.

- Generally, the demographic description of the membership has remained similar to that reported in 1990.

- There have been substantial changes in the distribution of members across settings in which they primarily practice. The percentage of members practicing in hospitals has declined markedly. This decline among hospital-based physical therapists has been accompanied by an increase in the percentage of physical therapists practicing in private practice settings, so that private practice was the setting with the largest percentage of members.

- Physical therapists cannot be categorized by a single practice setting. The majority of members practice in multiple settings, in addition to the one in which they primarily practice.

- The largest percentage of respondents have been practicing between six and ten years. In all previous surveys, the largest percentage of respondents had practiced between one and five years.

- Differences in a number of variables were found between male and female members of the Association. Men tended to have positions characterized by higher gross incomes and more responsibility. The career path of women was characterized by more career interruptions than men reported.

- Differences between graduates of different levels of professional education programs were noted on a large number of variables.

- The greatest percentage of time for all respondents was spent on direct patient care.

II. INTRODUCTION

Purpose

The 1993 Active Membership Profile was conducted to provide information on the demographic characteristics of American Physical Therapy Association members. Information provided will be used for two purposes. The data collected in 1993, in conjunction with similar data collected through past surveys, will aid the American Physical Therapy Association in implementing its strategic planning process. The second purpose of the study is to provide a description of the Association membership to all interested parties.

Method

The survey instrument was designed to gather information in six categories:

- Biographic information
- 1992 Employment information
- Current professional information
- Educational information
- Participation in Association activities
- Attitudes toward professional issues

The design of the survey was built upon the methods established in previous surveys. Some items were refined; some new areas were introduced; and other items were deleted. The 1993 survey instrument was developed by Association staff and pilot tested with physical therapists on the staff of the American Physical Therapy Association. After final refinements, the survey instrument (Appendix A) and an explanatory cover letter (Appendix B) were mailed to a random sample of 6,000 active members. Active membership is comprised of physical therapists. There are students and affiliate members of the APTA as well.

Only one survey instrument was not delivered because the member was no longer residing at the address to which the instrument was mailed. A total of 2,937 survey instruments (49.0%) were returned and entered into a data file. Based on this response rate, percentages reported may differ from the population of all members by, at most, less than two percent.

Data were entered into a file that could be accessed by the Statistical Package for the Social Sciences (SPSS-PC). All analyses were done using SPSS-PC. This report includes frequency counts and crosstabulations. In almost all cases, results are presented in terms of the percentage of active members responding to an item. Upon request, more sophisticated analyses can be made available.

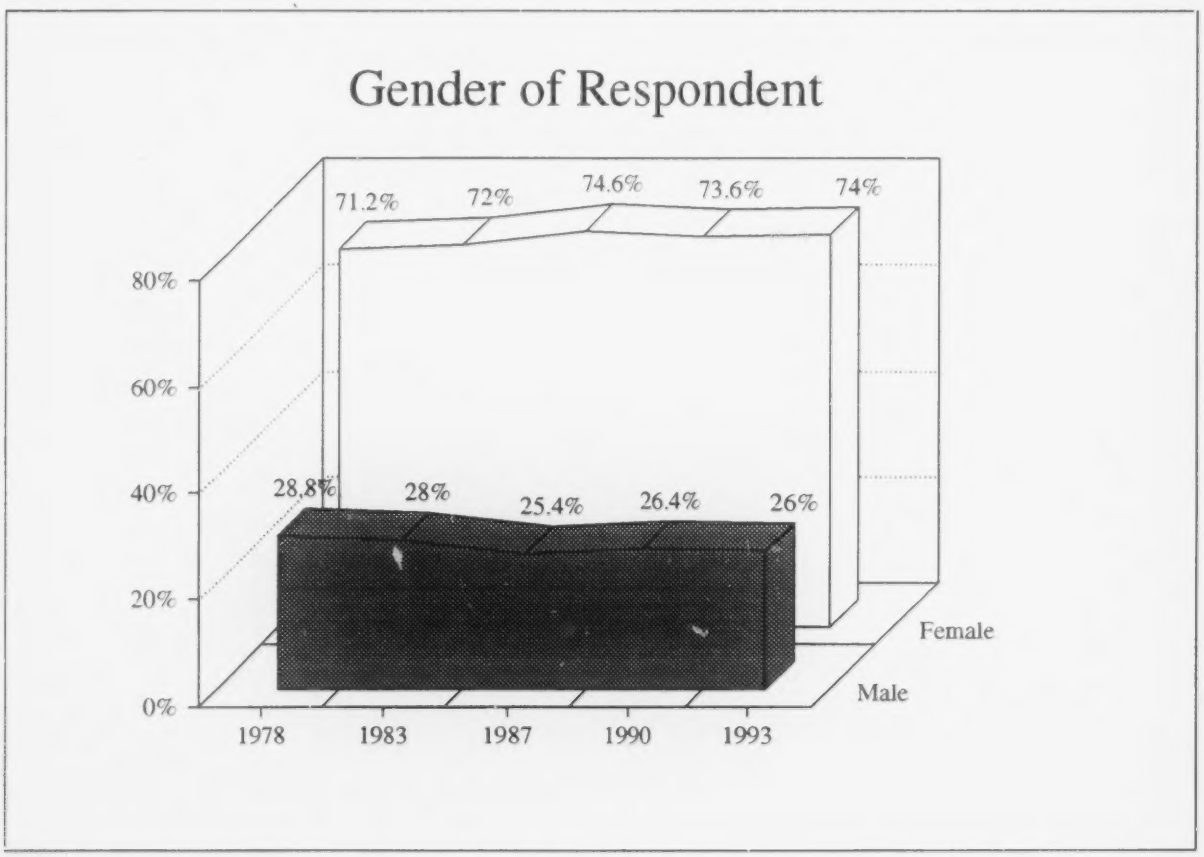
Results are generally reported in the order in which questions were asked on the survey instrument, although some deviations may occur. Where available, comparable results from previous Active Membership Profile surveys are presented with the 1993 data so that trends can be identified and reported.

III. FINDINGS

BIOGRAPHIC INFORMATION

Gender

The membership of the Association has remained predominantly female, although a slight change has been noted since 1990.[1] The percentage of female members had increased slightly between 1978 and 1987[2]; in 1990, however, the percentage decreased slightly, from 74.6 percent to 73.6 percent. In 1993, the percentage increased slightly to 74.0 percent, thus reverting to the trend established between 1978 and 1987. It appears that the high percentage of women in the profession will continue into the future. Recent data collected by the American Physical Therapy Association[3] have shown that nearly 77 percent of the students in entry-level programs who are in their final year of study are female.



Age

The age of active members has continued to increase steadily since 1978, with increases in both mean and median age. Further, the percentage of members under 30 years of age has declined. The largest percentage of members (51.9%) continues to be the age groups between the ages of 30 and 39. In fact, the percentage of active members within this age cohort has increased substantially. This increase has been accompanied by a considerable decrease in the percentage of members who are between 20 and 29 years old.

Male active members continue to be older than female members. The mean age of men was 39.1 years, while the mean age for women was 36.7 years. These results were consistent with 1990 survey results, when the mean age for men was 39.2 years and the mean age for women was 35.5 years.

Age of Respondent

Age in Years	1978 %	1983 %	1987 %	1990 %	1993 %
20 - 24	11.3	6.6	7.0	5.2	0.4
25 - 29	29.8	28.8	21.7	20.3	16.6
30 - 34	19.7	26.3	25.3	23.0	26.8
35 - 39	11.3	14.0	18.1	20.2	25.1
40 - 44	8.4	7.7	11.5	13.0	12.3
45 - 49	7.2	5.3	5.6	7.4	8.2
50 - 54	6.4	4.7	4.5	4.8	5.8
55 - 59	4.2	3.6	3.2	3.3	2.6
60 - 64	1.6	2.3	2.3	2.1	1.4
65 and older	0.2	0.8	0.8	0.7	0.8
Mean Age in Years	34.7	35.1	35.7	36.5	37.3
Median Age in Years	31.8	32.8	34.0	35.0	36.0

Race/Ethnic Origin

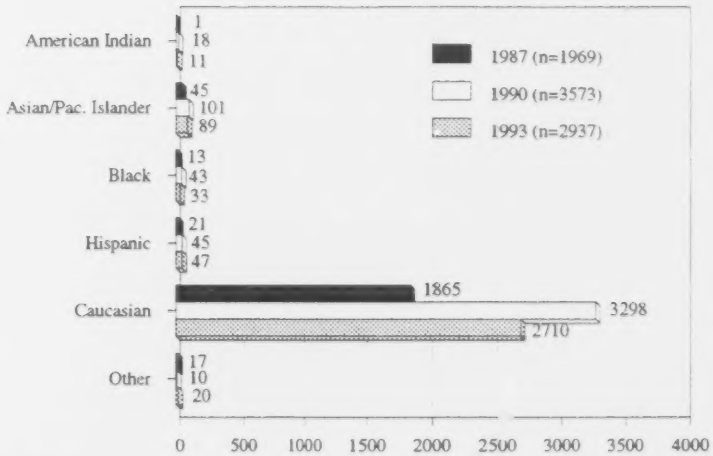
The membership of the Association has continued to be predominantly Caucasian. The percentage of active minority members has, however, increased since 1987. This finding continues the trend in minority membership reported in the previous Active Membership Profile Survey.[1] Asians continue to be the minority group with the highest percentage representation within the Association.

Because the research design used a sample of the active members of the Association, the absolute number of minorities represented in the sample is quite small. Therefore, to place the reported percentages in a more meaningful context, frequencies of each ethnic group responding to the survey are also included.

Race or Ethnic Origin

Race/Ethnic Origin	1978 %	1983 %	1987 %	1990 %	1993 %
American Indian	.04	.06	0.1	0.5	0.4
Asian/Pacific Islander	1.30	1.54	2.3	2.9	3.0
Black	1.41	1.37	0.9	1.2	1.2
Hispanic	0.63	0.84	1.1	1.3	1.6
Caucasian	96.30	95.70	95.1	93.8	93.1
Other	0.33	0.52	0.9	0.3	0.7

Number of Respondents by Race/Ethnic Origin



These frequencies will give the reader another perspective from which to study the data. It is important to realize, however, that these frequencies do not represent the total minority membership of the Association.

Years As Physical Therapist

Information about the number of years that therapists have been practicing has taken on great importance. Physical therapy has been, and continues to be, faced with a shortage of personnel. The length of an individual's career has implications for the size of the physical therapy active labor force.

The number of years that active members have been practicing has increased in a manner similar to the member age. Historically, the largest percentage of respondents has practiced for five years or less. However, this percentage has consistently decreased since 1978, so that among respondents to the current survey, the largest proportion of respondents have been practicing between six and ten years.

Years As Physical Therapist

Years as PT	1978 %	1983 %	1987 %	1990 %	1993 %
1 -5	38.0	34.4	31.0	27.4	19.0
6 - 10	21.8	25.9	24.4	22.1	28.3
11 - 15	12.2	15.2	17.2	19.0	21.8
16 - 20	9.7	8.4	10.3	13.1	13.8
21 - 25	7.9	5.7	6.7	7.1	5.6
26 - 30	6.1	5.4	5.0	5.7	6.3
31 - 35	3.2	3.3	3.4	3.1	2.8
36 - 40	0.7	1.1	1.6	2.0	1.5
More than 40	0.4	0.7	0.5	0.5	0.9
Mean Number of Years	11.2	11.2	11.8	12.6	13.3
Median Number of Years	8.3	9.0	9.0	11.0	11.0

The mean and median number of years of practice has increased correspondingly. Respondents to the survey have been practicing for an average of 13.3 years. This continues the increasing trend that has been evident since data were first collected in 1978. The reported pattern of years of practice differed between males and females. The mean number of years of practice for men decreased since 1990, while the mean among women has increased; however, the mean number of years of practice among men remains slightly greater. The mean for men has decreased to 13.6 years, a decrease of 0.5 years since 1990. The corresponding figure for women was 13.1 years, an increase of 1.1 years.

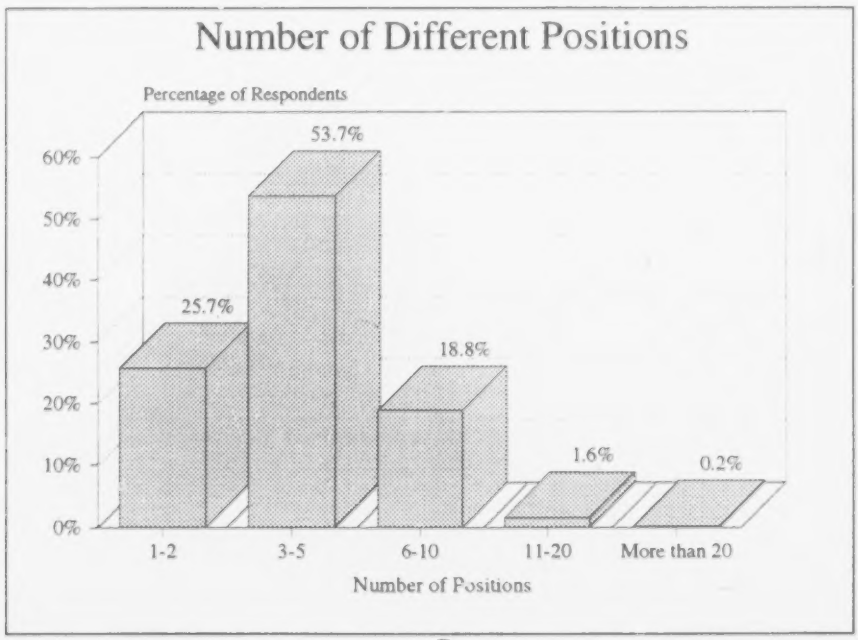
Years in Current Position

In addition to issues surrounding the absolute number of physical therapists, the profession has been interested in questions about the recruitment and retention of physical therapists. In order to derive more complete information about recruitment and retention issues, respondents were asked how long they have been practicing in their current position. This question had not been asked in previous surveys. Examining these data over time will begin to provide information on the length of time physical therapists remain in particular settings.

As shown in the table on the preceding page, the vast majority of respondents (69.8%) have been in their current position between one and five years. At the other end of the continuum, only a very small percentage of respondents (2.5%) has been practicing in a current position for more than 20 years. Thus it appears, based on length of time respondents have been practicing and the amount of time they have been at their current position, that there has been a substantial amount of turnover within the profession.

This variable was studied based on gender of respondents as well. Men had been in their current position for a substantially longer amount of time than their female colleagues. The mean number of years that male respondents were in their current position was 6.2 years. The comparable statistic among women was 4.6 years.

Respondents were also asked to indicate the number of different positions they had held since becoming a physical therapist. More than half the respondents (53.7%) have held three to five different positions since beginning their career. A substantial proportion of respondents (25.7%) have been employed in one or two different positions during the course of their career. On average, respondents have been employed in 4.2 positions since becoming a physical therapist. The number of positions was studied based on gender as well. Female respondents have been employed in a slightly larger number of positions than male respondents. The mean number of positions held by women throughout the course of their careers was 4.2. The comparable figure among men was 3.9.



States in Which Licensure Is Maintained

These data are similar to those reported in previous surveys. More than seven of every ten active members (71.7%) were licensed in one state. The percentage of individuals holding multiple licenses has remained relatively constant since the survey was initiated in 1978. Currently, the mean number of states in which licensure was held was 1.37. There was no difference between men and women. Both sexes were licensed in, on average, 1.37 states.

Number of States in Which Licensure Is Maintained

Number of States	1978 %	1983 %	1987 %	1990 %	1993 %
0	---	---	2.2	---	----
1	67.5	67.6	67.1	69.0	71.8
2	26.2	25.4	24.8	23.8	22.1
3	5.0	6.1	4.7	5.5	4.8
4-6	1.2	0.8	0.9	1.7	1.2
7-9	0.1	0.1	0.2	0.2	0.1
10 or more	0.1	0.1	0.2	---	---

1992 EMPLOYMENT INFORMATION

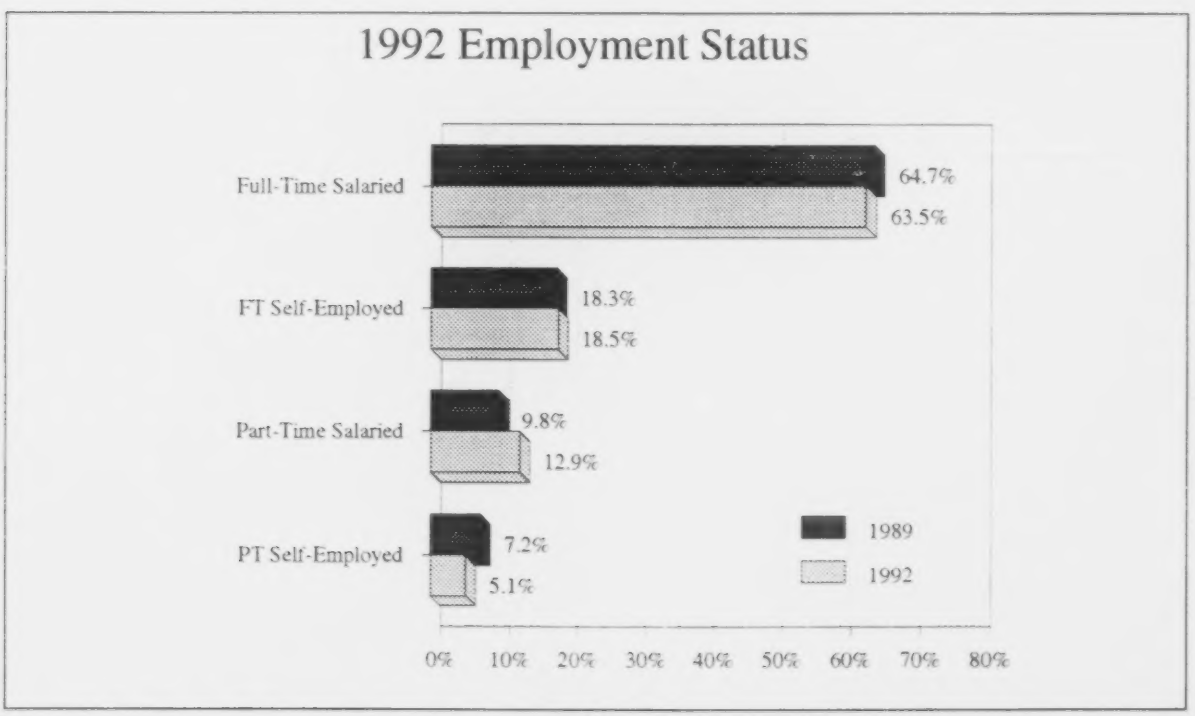
The percentage of active members who were employed throughout the entire 1992 calendar year was 92.7 percent. This was an increase of more than 3 percent from the 1990 survey.

Employment Status

The largest percentage of active members continued to be full-time salaried individuals. Nearly two of every three respondents (63.5%) were classified in this employment category. Although the majority of members were full-time salaried employees, the percentage of individuals in this employment category decreased in comparison to 1990.

This was the second time in succession that the percentage of members who were full-time salaried employees decreased. This decrease was accompanied by an increase of slightly more than 3 percent for part-time salaried active members.

As in the past, there continued to be substantial gender differences in employment status. Men were much more likely than women to be self-employed. Indeed, nearly three times as many men indicated that this was their appropriate employment status. In contrast, women were much more likely to be employed on a part-time basis; more than one-fifth (23.1%) of the female respondents maintained part-time employment status. This percentage included women who practiced on either



a part-time salaried or part-time self-employed basis. It was extremely unlikely for a man to be employed on a part-time basis. Fewer than 1 in 20 male active members (4.3%) indicated that they were either salaried or self-employed on a part-time basis. (Note that part-time employment status was defined as less than 35 hours per week.)

Percentage of Respondents by Employment Status

Employment Status	Female			Male		
	1986 %	1989 %	1992 %	1986 %	1987 %	1992 %
Full-Time Salaried	68.1	65.9	65.2	65.4	61.5	59.0
Full-Time Self-Employed	9.7	11.9	11.7	29.4	34.8	36.7
Part-Time Salaried	12.8	12.9	16.8	1.7	1.6	2.5
Part-Time Self-Employed	9.5	9.2	6.3	3.5	2.1	1.8

Income

The income of survey respondents was studied in a number of ways. Initially, income was analyzed based on the employment status of respondents. As expected, members who were self-employed on a full-time basis earned, by far, the highest mean income. On average, this group earned (in terms of gross earned income) more than twice as much as those respondents who indicated that they were full-time salaried individuals during 1992. Mean earned income for all respondents who practiced on a full-time basis was substantially more than it had been in 1989.

When gross earned income was studied based on gender and employment status, substantial differences were noted between men and women. Male respondents earned more than female respondents in all employment categories. Men who indicated that they were self-employed on a full-time basis earned, on average, nearly $50,000 (gross income) more than women in the same

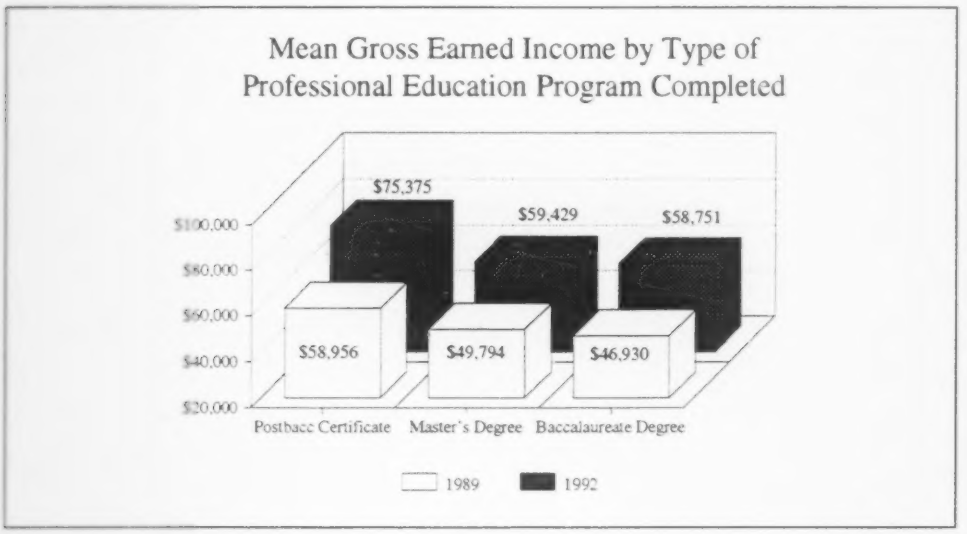
Gross Earned Income by Employment Status and Gender of Respondent

Employment Status and Gender	1989 Mean	1992 Mean
Full-Time Salaried	41,583	52,337
Female	38,211	48,816
Male	50,721	62,933
Full-Time Self-Employed	99,728	119,765
Female	73,396	93,699
Male	122,671	141,998
Part-Time Salaried	21,384	29,394
Female	21,032	28,703
Male	28,229	41,457
Part-Time Self-Employed	30,414	44,881
Female	26,317	37,948
Male	76,565	118,623

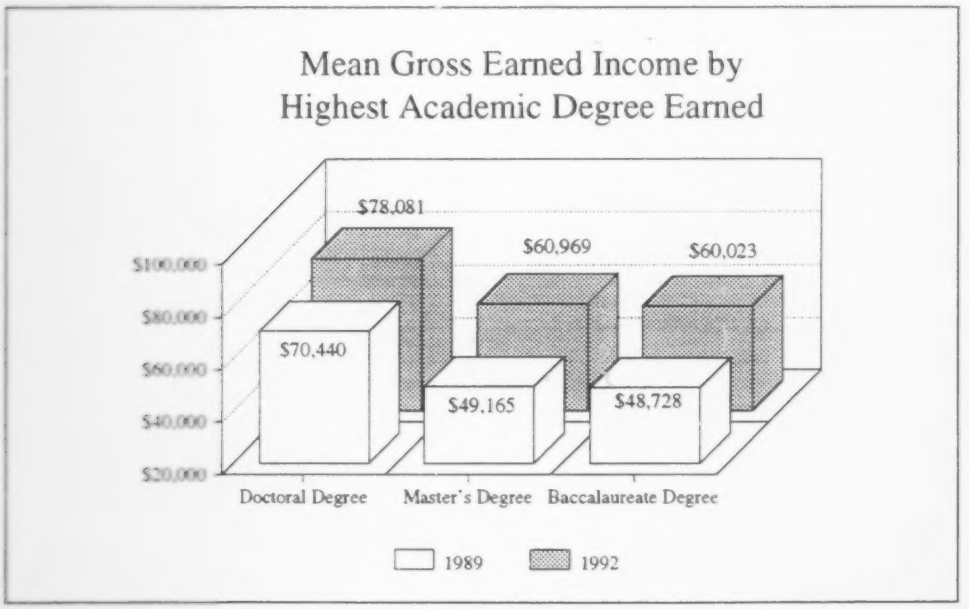
employment category. An even more startling finding was that men who stated that they were part-time self-employed earned, on average, approximately $70,000 more than full-time salaried female respondents, and nearly $25,000 more than full-time self-employed female respondents. It must be noted, however, that male part-time self-employed respondents practiced, on average, more than thirty hours per week.

Income also was studied from two perspectives based on the academic degree earned by respondents. First, income was analyzed on the basis of earned professional degree. There was very little difference between respondents with a baccalaureate degree versus those with a master's degree. The mean gross earned income for respondents with a master's degree was less than $1,000 more than for those individuals who had earned a bachelor's degree. The highest mean salary was found among respondents whose professional credential was a postbaccalaureate certificate. It is quite likely, however, that the higher salaries found among this latter group of respondents was due to the length of time that they had been practicing, rather than the type of

degree that was earned. Members with a postbaccalaureate certificate had been in practice, on average, longer than members who had earned either a baccalaureate degree or a master's degree.



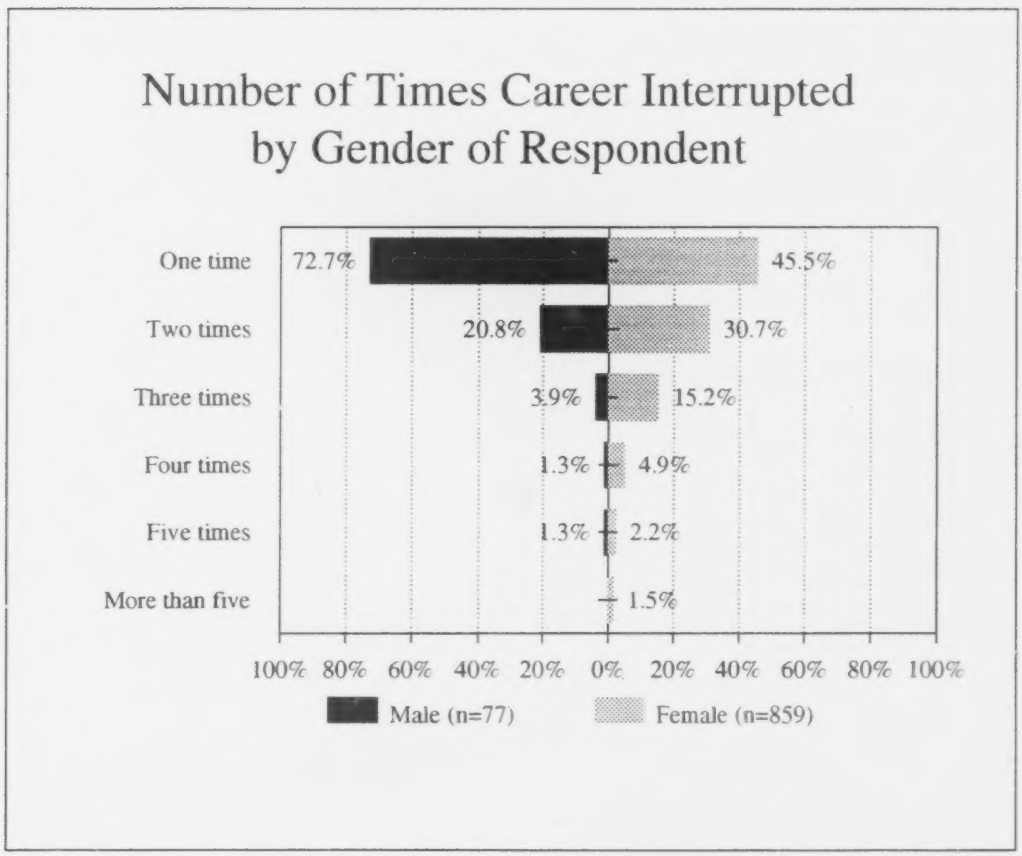
When highest earned degree (regardless of discipline) was studied, those individuals with doctoral degrees had the highest mean salary. It is important to note, however, that the number of individuals responding to this item who had earned a doctorate was substantially smaller than the number of respondents at other degree levels. Those individuals who had earned a master's degree (either professional or postprofessional) had on average, a slightly higher income than did individuals who had earned a bachelor's degree.



Career Interruptions

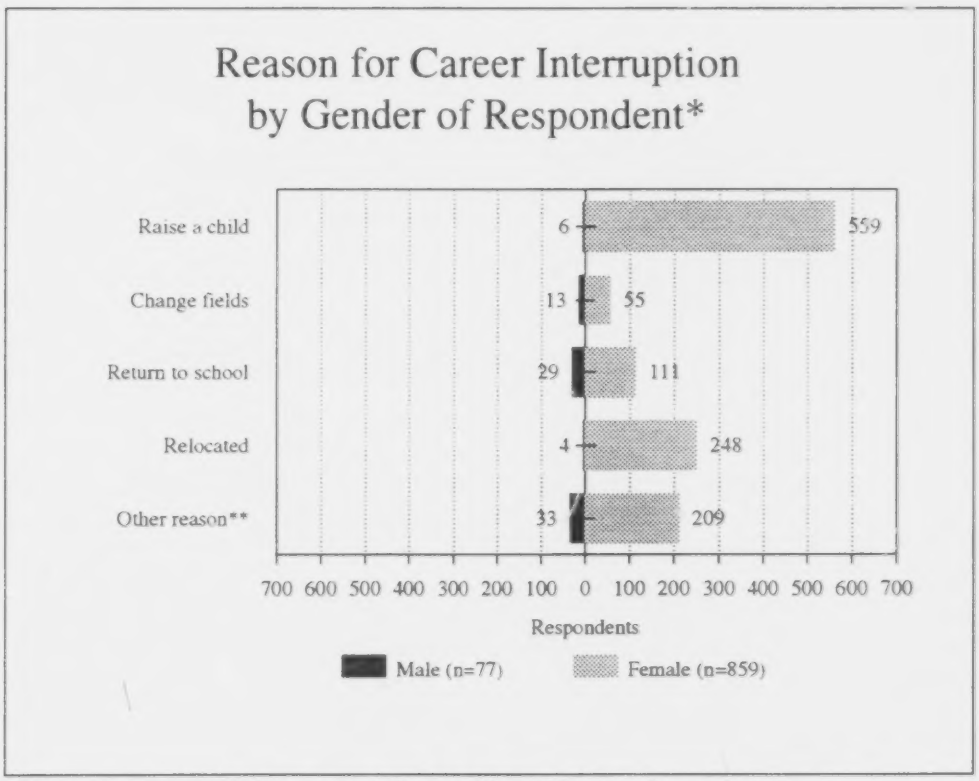
With the profession confronted by a shortage of personnel, information about the pattern of a physical therapist's career is extremely important. To help define this career pattern, respondents were asked if they had ever interrupted their career and, if so, how many times these career interruptions had occurred.

Nearly one-third (32.0%) of respondents had interrupted their career for a period of time. This was a very slight increase from the percentage of respondents (31.2%) who reported career interruption(s) in 1990. Female respondents were much more likely to interrupt their careers than were their male counterparts. Nearly two of every five female respondents (39.8%) had interrupted their careers, while only 10.2 percent of male respondents reported a suspension in their careers. Percentages among both sexes increased in comparison to 1990 survey respondents.



Further, the number of times a career was interrupted differed substantially between male and female respondents. The vast majority of male respondents who had interrupted their careers (72.7%) had experienced only one career interruption. Women, although typically experiencing one career interruption (45.5%), were more likely than men to have had their career interrupted a number of times.

The reasons for these interruptions also differed based on the gender of the respondent. Women overwhelmingly interrupted their careers to devote time to raising their children. Male respondents, on the other hand, were more likely to have interrupted their career to return to school or to change career fields. These reasons were consistent with those found in the previous studies of active members.[1,2]



*Responses are not additive, as respondent could provide more than one reason.

**Most frequent reason in the "other reason" category was relocation due to change in spouse's job.

CURRENT PROFESSIONAL INFORMATION

Current Employment Status

Since 1978, there has been a consistently slight decline in the percentage of members who are full-time salaried employees. This decrease in the percentage of full-time salaried members had been accompanied by a steady increase in the percentage of members who are full-time self-employed. In 1993, however, the data were slightly different. Although the percentage of full-time salaried respondents continued to decline, the percentage of full-time self-employed respondents decreased slightly as well, from 18.1 percent of the 1990 active membership to 17.0 percent of the current membership. The most substantial gain in percentage of respondents was noted within the part-time salaried category. Finally, the percentage of unemployed and retired members has continued to decline. Only slightly more than 1 percent of the membership is not practicing at all.

Current 1993 Employment Status

Employment Status	1978 %	1983 %	1987 %	1990 %	1993 %
Full-Time Salaried	69.5	65.1	62.7	62.3	60.9
Full-Time Self-Employed	10.0	14.6	15.8	18.1	17.0
Part-Time Salaried	10.8	10.0	10.4	10.7	15.1
Part-Time Self-Employed	4.3	6.6	7.7	6.5	5.8
Retired	0.6	0.7	0.4	0.4	0.2
Unemployed (not retired)	4.8	3.0	3.0	1.9	1.0

Crosstabulation of current employment status with 1992 employment status revealed that status remained consistent between the two years. Part of the reason for the increase in the percentage of part-time salaried respondents (as reported in the previous table) may be due to the fact that nearly 1 in 4 members in this category (23.7%) were full-time salaried personnel one year ago.

There were marked differences in the 1993 employment status of members based on gender. Men, on the one hand, were more than three times more likely to be self-employed on a full-time basis. Women, on the other hand, were much more likely to practice part-time. More than one-fourth (26.3%) of the female membership indicated that they were either part-time salaried or part-time self-employed. Among men, the corresponding percentage was only 5.3 percent. Further, although the percentages of unemployed members were quite small, women were substantially more likely than their male counterparts to be unemployed.

Crosstabulation of 1992 and Current Employment Status

1992 Percentage ↓	1993 Percentage →					
	FT Salaried	**FT Self-Employed**	**PT Salaried**	**PT Self-Employed**	**Retired**	**Unemployed**
Full-Time Salaried	**94.8**	6.4	23.7	9.2	25.0	50.0
FT Self-Employed	1.9	**89.9**	1.8	17.0	25.0	----
Part-Time Salaried	2.6	1.0	**70.2**	9.8	50.0	50.0
PT Self-Employed	0.7	2.7	4.3	**64.0**	----	----
Total	100.0	100.0	100.0	100.0	100.0	100.0

Percentage of Respondents by Current Employment Status by Gender

Employment Status	Gender					
	Female			Male		
	1987 %	1990 %	1993 %	1987 %	1990 %	1993 %
Full-Time Salaried	63.2	62.7	61.7	60.0	62.9	58.7
Full-Time Self-Employed	12.0	10.2	10.5	35.2	32.5	35.5
Part-Time Salaried	13.9	13.3	19.5	1.7	1.8	2.4
Part-Time Self-Employed	8.0	9.4	6.8	2.5	2.2	2.9
Retired	0.4	0.5	0.3	0.2	0.2	----
Unemployed	2.4	3.9	1.2	0.4	0.4	0.5

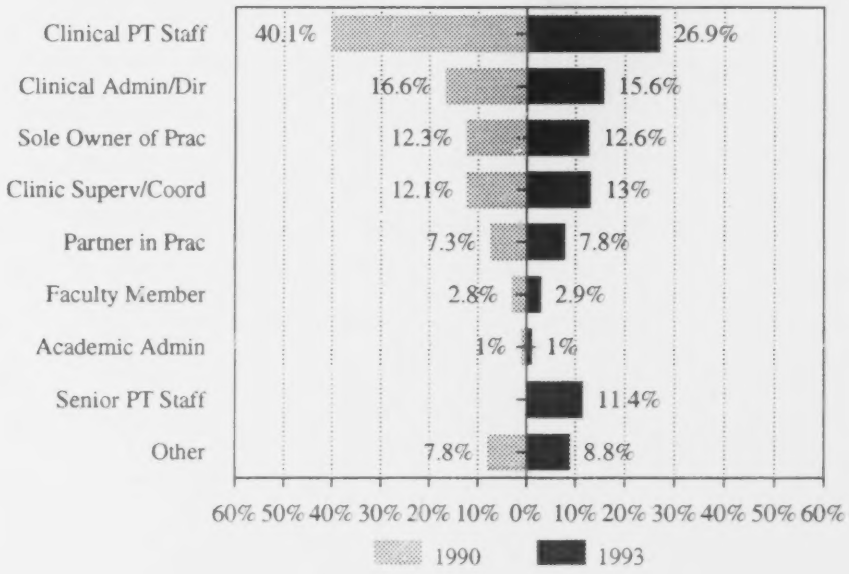
Current Primary Position

This item was changed slightly for this survey. Prior to 1993, respondents were asked only to indicate if they were physical therapy staff. This year, the staff category was divided into "clinical" and "senior" staff. The types of positions held by members has remained consistent since 1990.

The largest percentage of respondents continued to practice primarily as clinical staff, which includes both staff and senior staff positions. However, there was a slight decrease in the percentage of members who were clinical staff as compared to 1990.

Differences were noted, however, when primary position was analyzed based on gender. Men tended to hold positions whose job title implied greater responsibility. The percentages of sole owners of practices, partners in practices, and clinical directors were all higher among male respondents. Conversely, more than twice as many women as men held clinical staff (both clinical and senior staff) positions.

Current Primary Position of Respondents



Current Primary Position

Primary Position	Female			Male		
	1987 %	1990 %	1993 %	1987 %	1990 %	1993 %
Owner/Pres. of Practice/Business	9.1	8.9	8.9	26.4	21.2	23.0
Partner in Practice/Business	3.3	4.6	4.1	7.3	14.7	17.7
Clinical Admin./Dir.	13.5	14.0	14.1	22.0	24.3	19.8
Academic Admin./Dir.	0.6	0.7	1.1	1.2	1.7	0.7
Clinical Supervisor/Coor.	15.6	13.4	14.2	14.8	8.1	10.0
Academic Faculty	2.4	3.0	2.6	1.6	2.2	3.7
Senior Staff	---	---	13.2	---	----	6.1
Clinical Staff	46.2	47.0	31.8	20.9	21.8	13.4
Other	9.4	8.4	10.0	5.7	6.0	5.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

Primary position was also analyzed by the respondent's race or ethnic origin. It should be noted that caution is required when interpreting these results. Cell sizes were somewhat small in the 1990 analysis, and cell size has decreased slightly for the current analysis. Therefore, great variability is noted between the surveys. This variability is likely a function of the small numbers of individuals who were studied.

Clinical staff was the primary position regardless of a member's race or ethnic origin. Although there were differences across race or ethnic groups, the largest percentage of members within each group, except Blacks, indicated that they were clinical physical therapy staff. "Clinical supervisor or director" were also popular positions across all race or ethnic groups.

Race or Ethnic Origin and Current Primary Position

Primary Position	Asian		Black		Caucasian		Hispanic		American Indian	
	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %
Owner/President of Practice or Business	9.3	17.0	16.3	27.3	12.1	12.2	20.5	11.1	11.8	---
Partner in Practice or Business	2.1	6.8	---	3.0	7.7	7.9	6.8	2.2	5.9	---
Clinical Administrator or Director	13.4	3.4	30.2	21.2	16.6	16.0	22.7	11.1	11.8	18.2
Academic Administrator or Director	---	---	4.7	---	0.9	1.1	2.3	---	--	---
Clinical Supervisor or Coordinator	14.4	13.6	4.7	9.1	12.1	13.0	13.6	15.6	11.8	---
Academic Faculty	1.0	1.2	---	---	2.9	2.9	2.3	6.7	---	18.2
Senior Staff	---	19.3	---	6.1	---	11.3	---	6.7	---	27.2
Clinical Staff	51.5	30.7	30.2	24.2	40.1	26.9	29.5	33.3	41.2	9.1
Other	8.2	8.0	14.0	9.1	7.6	8.7	2.3	13.3	17.6	27.3

Facility or Institution

Prior to highlighting responses to this item, a vital point should be made. It would be incorrect to think of physical therapists as practicing in only one facility. The typical respondent practiced in multiple settings. Therefore, as the practice setting of respondents is reviewed, the reader must remember that this item refers only to the facility in which most or all of a therapist's practice takes place. Additional settings in which members practice are discussed later in the report.

The facility in which most of a member's practice takes place has changed substantially since 1978. When the membership profile was begun, nearly half (47.1%) the respondents practiced in a hospital setting. Percentages of members practicing in other settings did not approach this level. Between 1978 and 1983, there was a gradual and steady decline in the percentage of physical therapists practicing in hospitals.

When data were collected in 1987, this item was phrased differently. Respondents were asked to include all facilities in which they practiced. Thus, the percentage of physical therapists who indicated that they practiced in a hospital increased. Because this question was asked differently in 1987, those data are not included in this report.

In the current survey, the item was phrased in a manner similar to the wording prior to 1987. Results indicated major changes in practice setting. The percentage of respondents practicing in a private practice setting represented the largest proportion of membership. This percentage has tripled since data on members were first collected in 1978. This substantial change was accompanied by a corresponding decrease in the percentage of APTA members who practice in a hospital setting, so that, for the first time, the hospital setting did not employ the largest percentage of members. Thus, these data represent a culmination of a trend that has been observed since the Membership Profiles have been conducted.

It is important to note that this percentage (of members who practice in a private practice setting) includes owners, partners, and employees of a private practice. This figure does not discriminate between physician-owned and physical therapist-owned practices. The critical point here is that, regardless of ownership, this practice setting is becoming much more common among the membership.

Type of Facility or Institution in Which (or for Which) Respondents Practice

Facility/Institution	1978 %	1982 %	1983 %	1990 %	1993 %
Hospital	47.1	42.7	41.9	29.6	25.4
Private Office	9.9				
Private Physical Therapy Office		11.0	14.7	24.9	27.4
Physician's Office		3.0	2.8	2.2	1.8
Rehabilitation Center, with or without beds	9.2	8.5	9.1	10.8	N/A
Rehabilitation Center (inpatient and outpatient)	N/A	N/A	N/A	N/A	6.7
Rehabilitation Center (outpatient only)	N/A	N/A	N/A	N/A	6.4
Extended Care Facility/ Nursing Home	8.2	7.5	6.0	5.5	7.4
Home Health Agency	5.9	8.3	8.3	7.0	7.7
Public or Non-Public School	5.7	6.8	4.7	5.1	3.5
Academic Institution	5.2	4.2	4.3	4.0	4.2
Specialty Clinic	1.7	1.1	1.9	N/A	N/A
Residential Care Facility	1.5	1.5	1.1	N/A	N/A
Governmental Dept./Agency	1.4	1.1	0.9	N/A	N/A
Voluntary Health Agency	0.4	0.3	0.2	N/A	N/A
Prepaid Health Care Organization	0.3	0.8	0.9	1.2	1.1
Research Center	0.1	0.4	0.2	0.2	0.2
Industry	0.1	0.2	0.3	N/A	N/A
Other/Missing	3.0	2.7	2.7	9.5	8.2

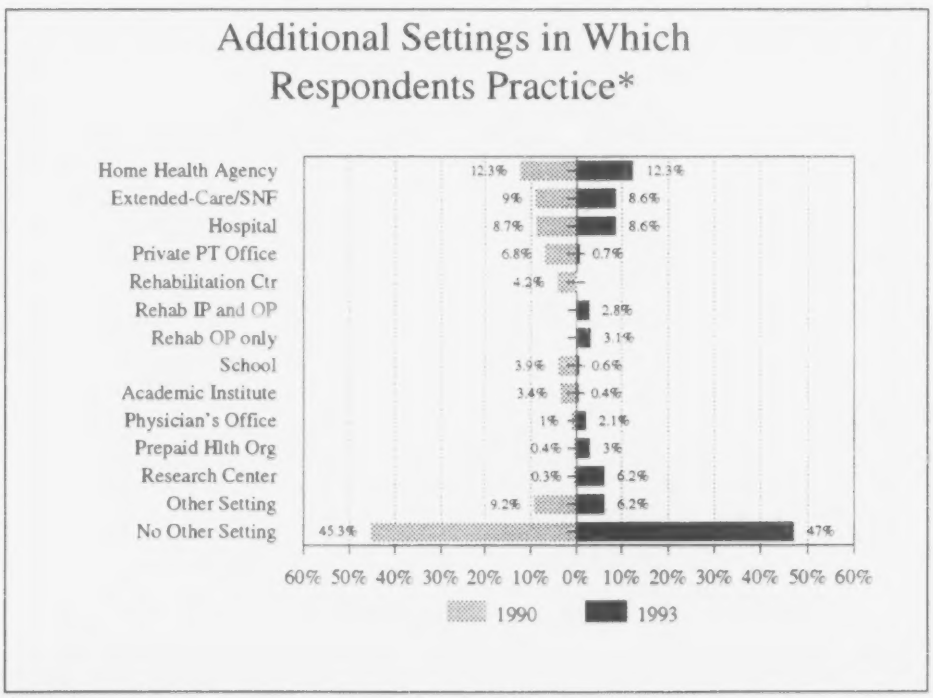
*N/A - Not specified as practice setting.

More than half the respondents (53.0%) indicated that they practiced in multiple settings. The setting cited most frequently by those with multiple practice settings was a home health agency. Nursing homes/extended-care facilities, hospitals, and research centers were also cited often.

Two potentially important points are raised by these results. First, the percentage of respondents who practice additionally in a private physical therapy office decreased substantially. Thus, it may be likely that the increase in the percentage of members practicing primarily in this environment is due largely to members who converted from the "additional" to "primary" category since 1990.

The second, and somewhat fascinating, point was the large increase in members working in a research center, although they practice primarily in another setting. This finding is quite important and should be tracked in the future, as it may signal an enhanced appreciation of and attention to research among the membership.

In general, however, the data point out that it is not accurate to characterize physical therapists as solely hospital-based, solely private practitioners or solely practitioners in some other setting. Rather, it is important to recognize that members are treating patients in a variety of settings.



*The percentages of respondents to this item are not additive, as each respondent could indicate more than one response.

Characteristics of Practice

Respondents were asked a series of questions that described some global elements of their practice. Members continued to be actively involved in clinical care. More than nine of ten respondents (91.2%) indicated that they saw patients in a typical day. This percentage has declined slightly from the 1990 level of 92.1 percent. This difference is, however, clearly not substantial. A sizable portion of the respondents (32.5%) stated that they provide contractual services. This was a slight increase from the percentage (32.0%) reported by 1990 respondents.

The concept of physician-owned physical therapy practices has been rather controversial. Policies of the American Physical Therapy Association discourage members from becoming involved in these arrangements. By and large members have, in fact, avoided being employed in physician-owned practices; only 6.4 percent of survey respondents indicated that they worked for a physician-owned physical therapy practice. The same percentage was reported in 1990.

The relationship between physical therapists and physical therapist assistants and aides has also created some debate. More than half the respondents (51.4%) indicated that they supervised a physical therapist assistant during a typical week. This was an increase of approximately 6 percent since 1990.

Global Characteristics of Practice

Description	Yes		No		Not Applicable	
	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %
Personally see patients in a typical day	92.1	91.2	7.9	8.8		
Provide contractual services	32.0	32.5	62.8	62.0	5.2	5.5
Work for a physician-owned physical therapy practice	6.4	6.4	82.4	28.3	0.6	65.3
Direct and/or supervise a physical therapist assistant in a typical week	45.7	51.4	50.2	43.4	4.2	5.2

In the past, a large proportion of the membership (67.9% in 1990) stated that they supervised the performance of a physical therapy aide. However, the term "aide" can describe a number of different individuals, depending on a particular facility's definition. To provide more information on supervisory patterns, the item seeking information on supervision of aides was expanded. Respondents were presented with a number of different types of supportive personnel, and were asked whether they supervised these categories of individuals. If they did supervise any of the categories, they were asked to indicate the number of personnel they managed.

Clearly, the largest percentage of respondents supervised on-the-job-trained physical therapy aides. Nearly three of every five (59.7%) respondents directed the activities of this category of personnel.

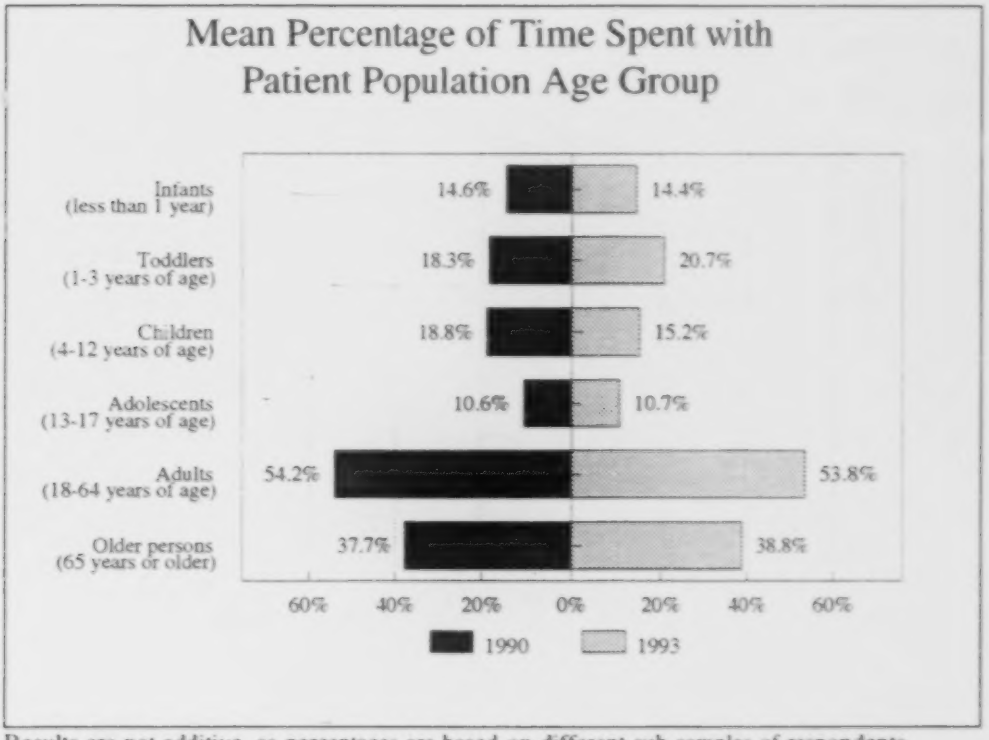
Although additional information was collected, additional questions remain. A substantial percentage of respondents (10.4%) indicated that they supervised aides whom they placed in an "other" category. The mean number of aides placed in this category was 3.9. Future administrations of this Profile must investigate further the types of individuals comprising this category.

Supervision of Supportive Personnel
Other Than Physical Therapist Assistants

Type of Aide Supervised	% of Respondents Who Supervise	Average Number of Personnel Supervised	Range
On-the-job-trained physical therapy aides	59.7	2.7	1-22
Certified athletic trainers	15.7	1.8	1-15
Exercise physiologists	10.9	1.6	1-30
Massage therapists	9.6	1.2	1-3
Kinesiotherapists	6.8	1.1	1-2
Other	10.4	3.9	1-60

Patient Population Age Group

Members indicated that they typically saw patients between the ages of 18 and 64 years. On average, more than half of respondents' time was spent with this age group. Older patients (those over age 65) were seen for more time than were any category of children. The age group typically seen less often than any other was adolescents. These patterns were consistent with results generated by respondents in 1990.

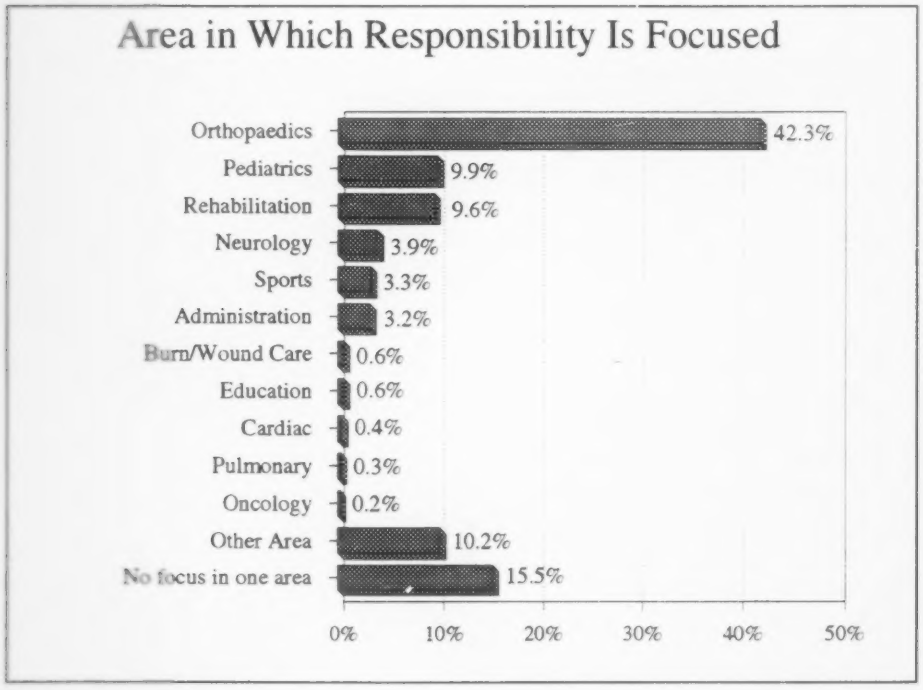


Results are not additive, as percentages are based on different sub-samples of respondents.

Focus of Responsibilities

Previous Active Membership Profile surveys asked respondents to describe the setting(s) in which they practiced. However, these surveys did not ask respondents to indicate the focus of their responsibilities. The question was asked this year, as it has become quite important to determine where physical therapists focus their practice. The areas of practice that were listed included clinical areas, ages of patients, and activities (e.g., education) that may have been adjunct to practice.

By far the largest percentage of respondents (42.3%) focused on orthopedics. Pediatrics and rehabilitation were also popular areas, although the percentages of respondents focusing in these areas did not approach the percentage of respondents indicating orthopedics as their focus. A substantial percentage of respondents (15.5%) indicated that they did not focus their practice in any one area.

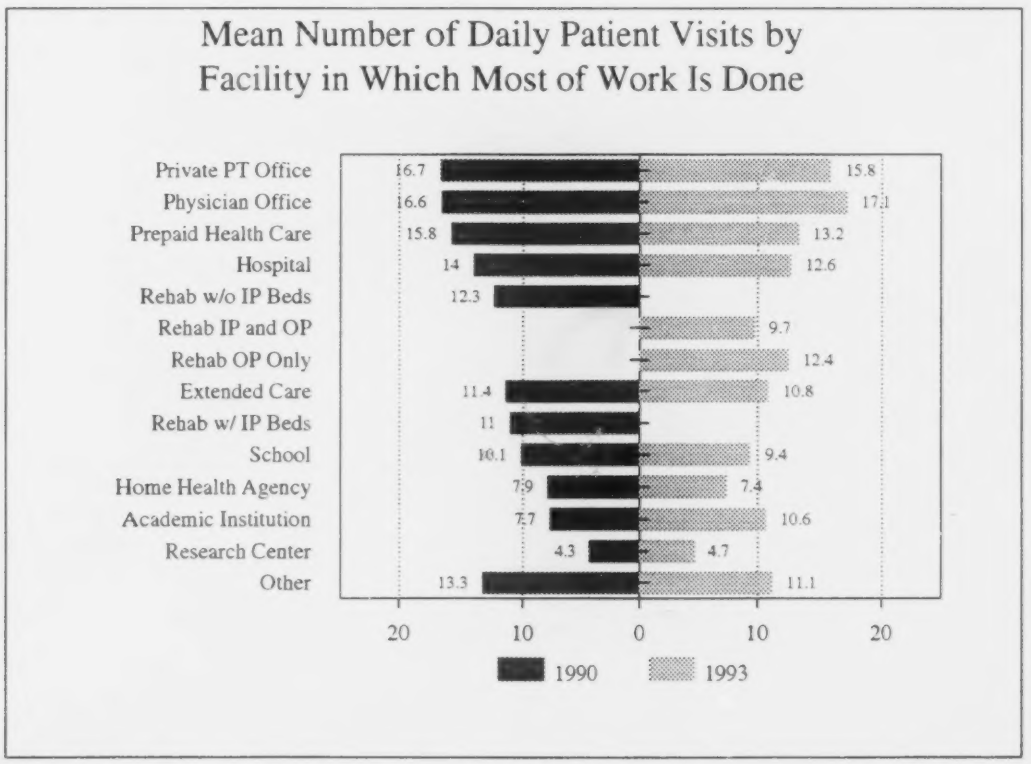


Total Number of Patient Visits

The mean number of daily patient visits reported by respondents was 12.6. This was a decrease of one patient visit since the 1990 Profile. The largest mean number of patients (17.1%) was seen in a physician's office. This was the only setting that had an increase in the mean number of patients since 1990. The mean number of patient visits per day reported by physical therapists who practiced primarily in a private physical therapy office was 15.8; the mean number of patients seen daily by hospital-based physical therapists was 12.6.

The mean number of daily patient visits also provided some insight into the diversity of physical therapy practice and reinforced the idea that physical therapists cannot be categorized within one practice setting. Individuals who are employed primarily in a research center or an academic institution also reported that they had an opportunity to provide direct patient care.

Only three individuals from a research center setting responded to this question; however, those respondents indicated that they provided direct care to an average of 4.7 patients per day. Respondents from academic settings reported that they saw an average of 10.6 patients per day. Thus, even though a respondent's primary responsibility was not necessarily patient care, they still were afforded the opportunity to test or treat patients.

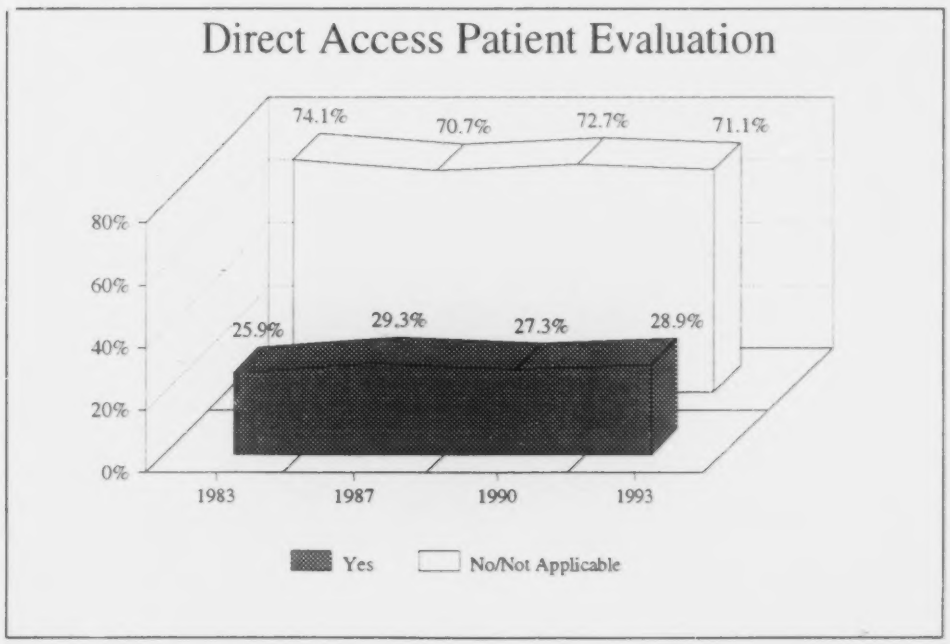


Further, patient care did not always take place in the facility in which the respondent primarily practiced. Hospital-based physical therapists, for example, made slightly more than two (2.1) visits per day to home-bound patients. Those respondents involved primarily in home health care also reinforced this statement. These therapists saw a substantial percentage (85%) of their patients in settings other than patients' homes.

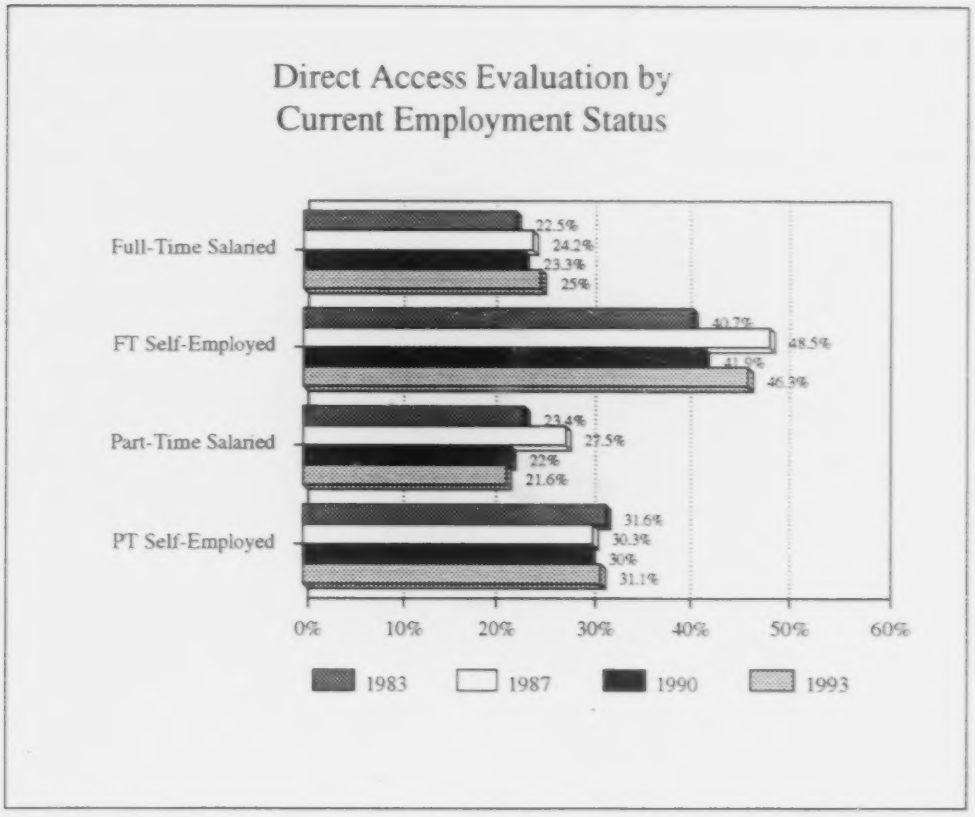
Direct Access Patient Evaluation

Direct access to physical therapy services (without requiring referral from another health care professional) has been, and continues to be, a goal of the Association. The survey instrument included two items that assessed the extent to which direct access was occurring within physical therapy practice.

The first dealt with evaluation through direct access. More than one-fourth of respondents (28.9%) indicated that they evaluated patients through direct access. This percentage is slightly more than the percentage reported in the previous Membership Profile, and is consistent with responses obtained since the question was first asked in 1983. Because the difference between the two most recent percentages is minimal, it is likely due to sampling differences rather than to changes in practice patterns.



Those individuals who indicated that they evaluated patients through direct access were then studied in greater detail. When patient evaluation through direct access was crosstabulated by current employment status, it was found that the percentage of respondents who provided direct access evaluation in three of the four employment categories had increased since 1990. The largest increase (approximately 5%) was found among full-time self-employed respondents. This reversed a finding among 1990 respondents.

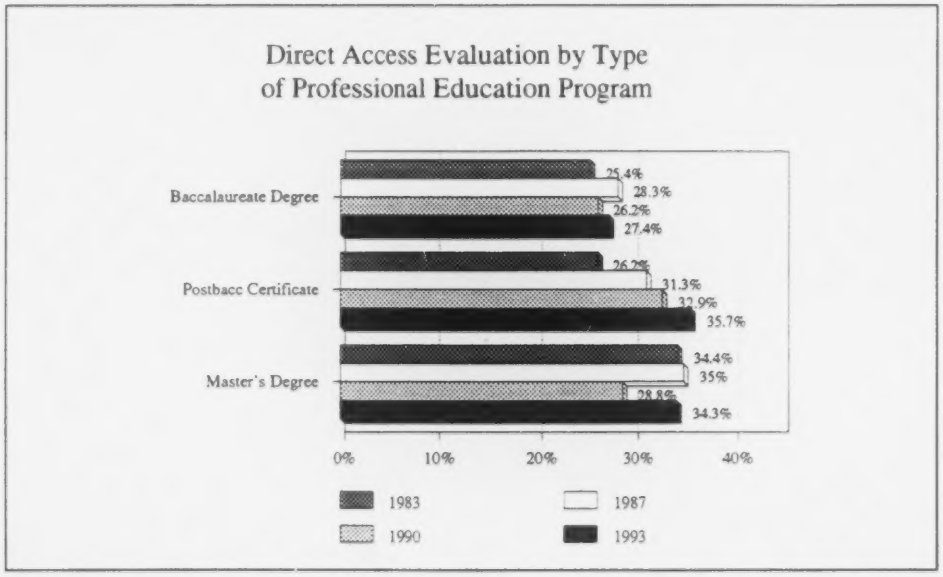


Crosstabulation of evaluation through direct access with primary position also generally revealed an increase from levels reported in 1990. The exception to this statement occurred among clinical directors. The percentage of respondents within this category who evaluated patients through direct access declined slightly. This replicated a finding discovered among respondents to the 1990 profile. One final note is warranted. Although percentages were reported for respondents involved in academics, the number of respondents within the categories "academic administrator" and "faculty" was small (n=4, n=16). Thus, these percentages must be read with this small number of respondents in mind.

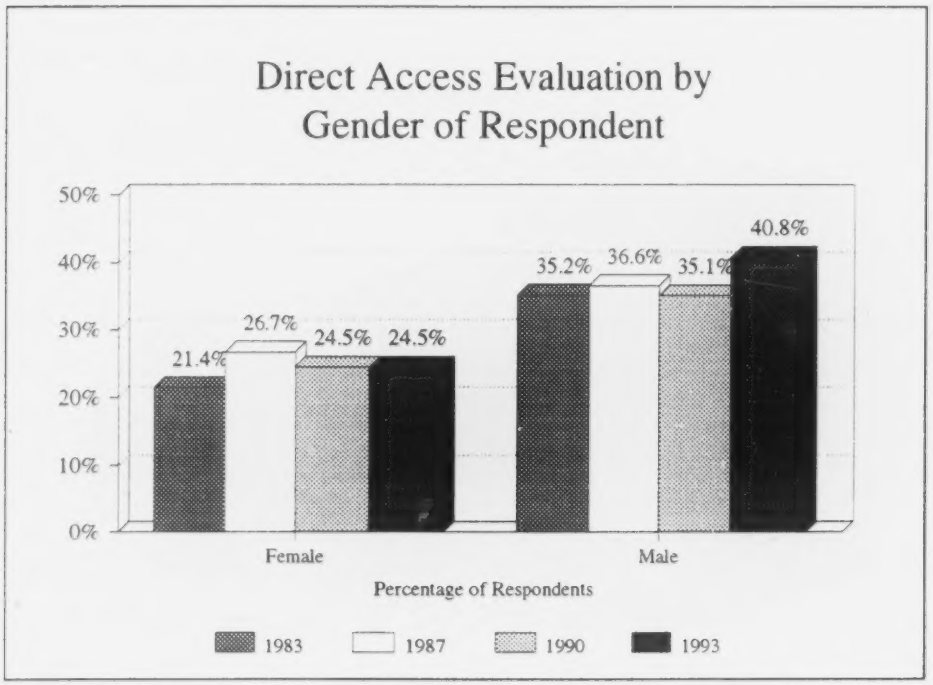
Direct Access Evaluation by Primary Position

Primary Position	1987 %	1990 %	1993 %
Owner/President	47.4	42.7	44.4
Partner in Practice	60.8	47.9	53.5
Clinical Administrator/Director	28.6	27.0	26.1
Academic Administrator/Director	16.7	55.9	40.0
Clinical Supervisor	27.2	18.8	20.3
Academic Faculty	28.6	47.1	64.0
Clinical Staff	20.3	21.2	---
Senior Staff PT	---	---	20.2
Staff PT	---	---	23.5
Other	31.6	24.5	25.4

When the provision of patient evaluation through direct access was crosstabulated with the type of professional program from which respondents had graduated, graduates of all levels of professional education programs were more likely to evaluate patients via direct access than were a similar sample of respondents in 1990. The most likely group to evaluate via direct access comprised those individuals who had earned a postbaccalaureate certificate. However, the biggest gain in percentage (5.5%) was found among recipients of a master's degree. The percentage among this latter group is similar to that found among postbaccalaureate certificate recipients.

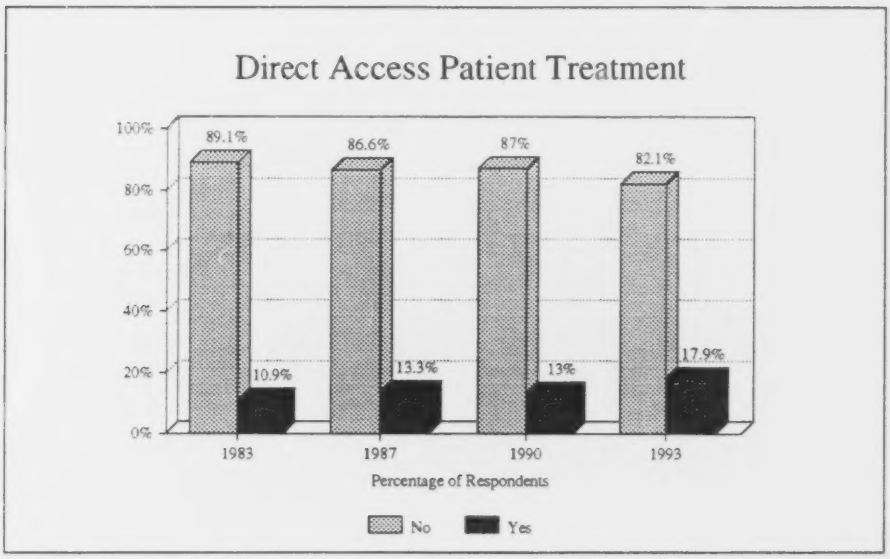


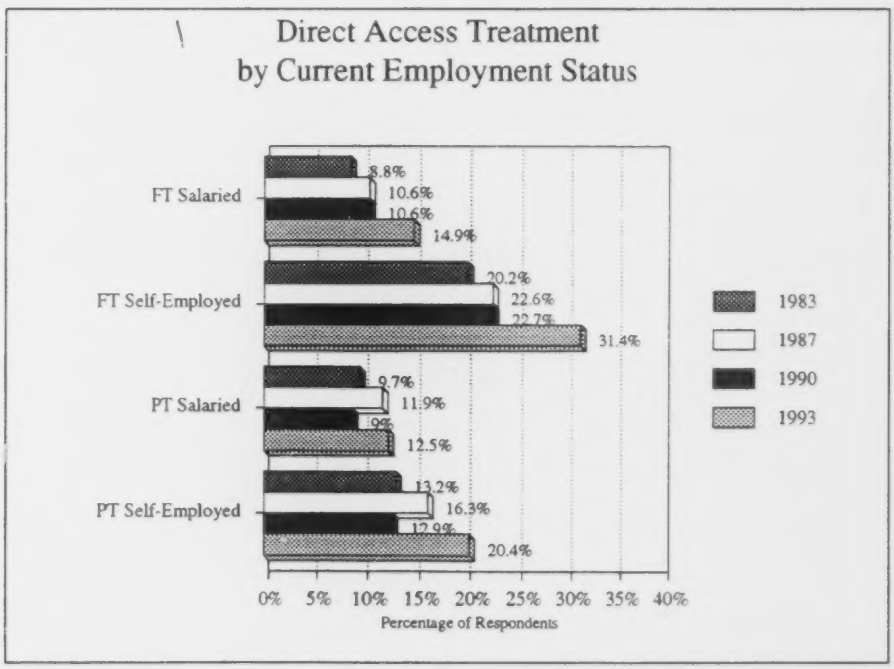
Crosstabulation of the provision of direct access evaluation with gender of respondents illustrated a pattern similar to other gender breakdowns of respondents. Among men, there was an increase in the likelihood of evaluating patients through direct access. The percentage of women who evaluated patients through direct access remained precisely the same as 1990. Thus, the discrepancy between male and female respondents who evaluated via direct access widened.



Direct Access Treatment

The percentage of respondents treating patients through direct access increased rather substantially from 1990. This increase is obviously a reflection of the increase in the number of states that have had favorable direct access legislation passed in the past three years. The percentage of members indicating that they treated patients without referral from another health care professional increased from 13.0 percent to 17.9 percent.

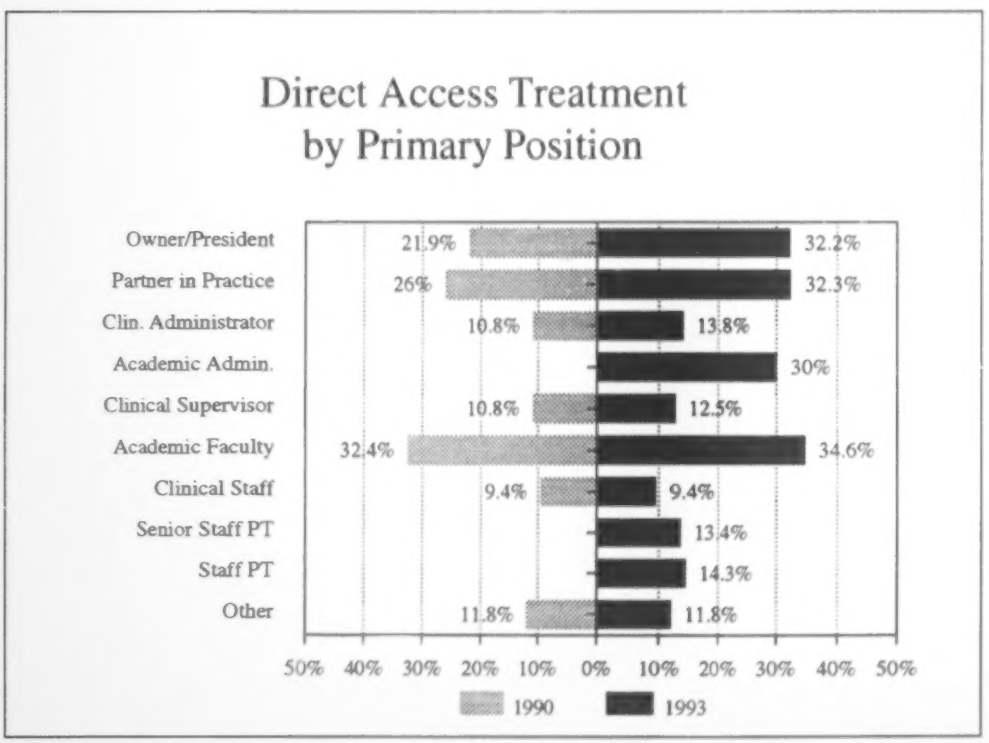




The same variables used to study evaluation through direct access were used to study treatment via direct access. When direct access treatment was crosstabulated with current employment status, there was substantial change between 1990 and 1993 among respondents in all employment categories. The largest increase (8.7%) was found among members who were full-time self-employed.

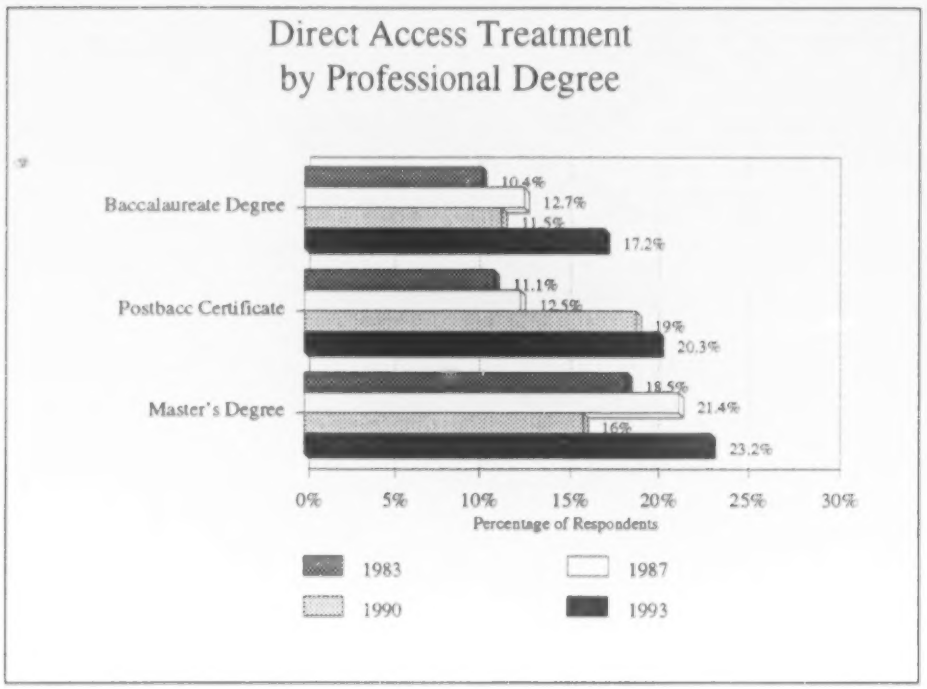
Responses to the item dealing with treatment through direct access further disclosed that therapists could fulfill a number of roles. For example, nearly one-third of respondents who indicated that they were members of a faculty (n=9; 34.6%) also treated patients without referral. The finding that faculty members treat patients, as well as teach and conduct research, reinforces the point that physical therapists do not fulfill only one role.

When respondents were categorized based on primary position, there was an increase in the likelihood of treating patients via direct access in all categories. The largest increase (10.3%) was found among owners or presidents of private practices. In comparison to 1990, a larger percentage of academic administrators treated patients via direct access. However, there were only a small number of respondents in this employment category.

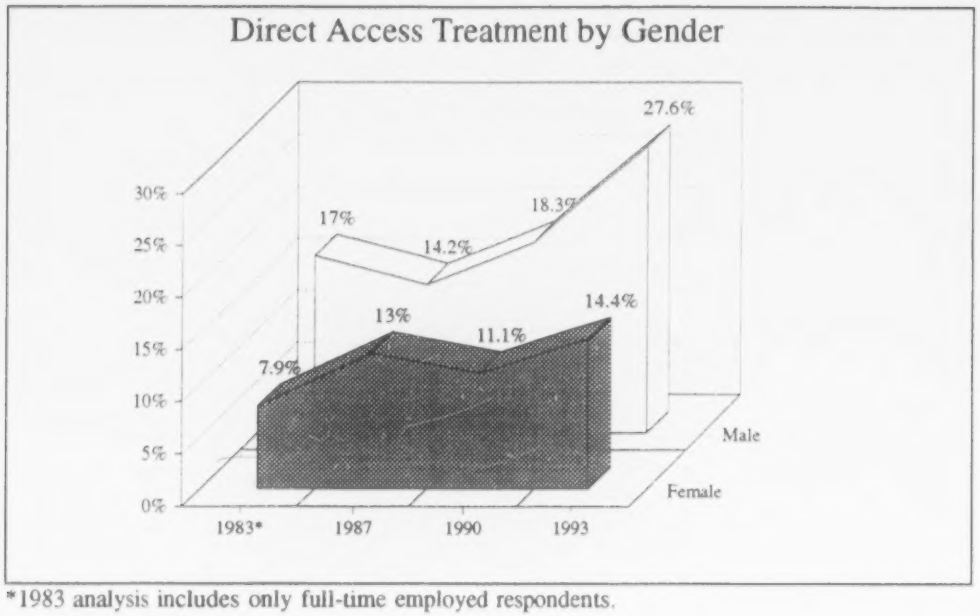


Although the degree of increase varied, all categories of primary position had larger percentages of respondents treating patients through direct access when compared to 1990 respondents.

When respondents were studied based on level of professional degree, there was consistency across all degree levels. Regardless of level, there was an increase since 1990 in the likelihood of a respondent treating patients without referral. The largest increase (7.2%) was found among members who had earned a master's degree.



Crosstabulation by gender revealed similar trends for male and female respondents. Both groups were more likely to treat patients without referral. However, the increase among men practicing in this mode occurred at a substantially greater rate from that of 1990. One other methodological note must be included here. When reviewing the data, it must be taken into account that in 1983 only physical therapists employed full-time were included in the analysis of the direct access question.



*1983 analysis includes only full-time employed respondents.

Hours Per Week Devoted to Practice

The mean number of hours per week devoted to practice or practice-related activities has remained essentially the same since 1990, decreasing by approximately one hour. The average amount of time devoted to practice decreased by less than one hour in three of the categories defining employment status, while it increased by less than one hour in the remaining category. In comparison to data that have been available since 1983, the mean amount of time devoted to practice has decreased slightly.

When employment status was further examined based on gender of respondent, the data indicated that in each employment category, men devoted more time to their practice than did their female colleagues. The most substantial difference was found among full-time self-employed respondents. Men in this category practiced, on average, 53.80 hours per week, while female respondents averaged 48.43 hours per week of practice.

Among full-time salaried respondents, those employed in research centers devoted the largest amount of time per week to their work. This finding should be interpreted with caution, however, as a very small number of members (n=4) indicated that they were in this employment category. Those respondents employed primarily in academic institutions worked, on average, 50 hours per week. The mean number of hours per week that full-time salaried respondents devoted to all practice- related responsibilities was 46.9 hours.

Full-time self-employed respondents spent more time on practice-related responsibilities ($\bar{X}$=51.4) than did full-time salaried respondents. Those individuals practicing in either a private physical therapy office or a physician's office spent, on average, the most time fulfilling the responsibilities of their position.

Hours Per Week Devoted to Practice-Related Activities by Employment Status and Gender

Employment Status and Gender	1983 Mean Hrs/Week	1987 Mean Hrs/Week	1990 Mean Hrs/Week	1993 Mean Hrs/Week
Full-Time Salaried	---	46.2	46.9	46.6
Female	47.4	45.8	46.3	46.0
Male	50.8	47.4	48.8	48.5
Full-Time Self-Employed	---	51.7	51.7	51.3
Female	49.8	48.4	49.3	48.4
Male	55.8	54.6	53.9	53.8
Part-Time Salaried	---	24.7	25.4	24.5
Female		24.4	25.0	24.6
Male		29.4	34.3	25.0
Part-Time Self-Employed	---	21.4	22.6	23.0
Female		21.3	22.1	22.8
Male		22.2	26.9	24.6

Number of Hours Per Week Devoted to Practice by Current Employment Status and Facility in Which Most of Practice is Conducted

Employment Status and Facility	Mean Hrs/Week	Number of Respondents	Employment Status and Facility	Mean Hrs/eek	Numberof Respondents
FT Salaried	46.9	1646	**FT Self-Employed**	51.4	477
Hospital	47.0	529	Hospital	50.7	32
Home Health	46.2	81	Home Health	48.0	60
Rehab IP and OP	46.1	150	Rehab IP and OP	47.5	4
Extended Care	46.5	135	Extended Care	50.4	18
Academics	50.0	71	Academics	55.0	1
Research Center	50.8	4	Research Center	-----	-----
Private PT Office	46.8	314	Private PT Office	52.6	309
Physician Office	48.9	133	Physician Office	54.6	10
Rehab OP only	-----	-----	Rehab OP only	50.7	14
School K-12	42.8	48	School K-12	41.1	14
Prepaid Health Care	45.1	23	Prepaid Health Care	----	----
Other	44.6	122	Other	52.0	15
PT Salaried	24.6	418	**PT Self-Employed**	23.1	156
Hospital	24.8	111	Hospital	22.6	20
Home Health	24.4	49	Home Health	21.4	33
Rehab IP and OP	26.3	29	Rehab IP and OP	22.0	1
Extended Care	24.9	36	Extended Care	22.2	10
Academics	18.1	18	Academics	24.5	2
Research Center	----	---	Research Center	-----	-----
Private PT Office	24.0	90	Private PT Office	25.5	48
Physician Office	25.0	4	Physician's Office	34.0	1
Rehab OP	25.0	21	Rehab OP only	16.2	5
School K-12	24.5	26	School K-12	23.5	12
Prepaid Health Care	29.3	9	Prepaid Health Care	----	----
Other	26.2	25	Other	22.1	24

Percentage of Time Devoted to Various Activities or Responsibilities

As expected, the respondents' greatest percentage of time was devoted to patient care. This finding held true regardless of employment status. Respondents employed on a part-time basis devoted an even larger percentage of their time to patient care. This was an expected finding, for these individuals typically are hired to provide patient care and often have no administrative responsibilities. Although respondents also spent substantial amounts of time on administrative and supervisory matters, these responsibilities did not approach the proportion of time spent providing direct patient care.

Time for Each Activity by Employment Status

Activity/Responsibility	1990 %	1993 %	Activity/Responsibility	1990 %	1993 %
Patient Care (n=2679)			**Screening & Prev.** (n=539)		
FT Salaried	65.8	62.4	FT Salaried	5.8	6.5
FT Self-Employed	70.6	67.8	FT Self-Employed	6.0	5.7
PT Salaried	74.2	74.6	PT Salaried	7.6	6.6
PT Self-Employed	71.2	71.5	PT Self-Employed	7.4	7.0
Administration/Mgmt (n=2007)			**Research** (n=238)		
FT Salaried	23.2	26.6	FT Salaried	9.7	10.7
FT Self-Employed	18.1	19.6	FT Self-Employed	5.3	5.9
PT Salaried	15.1	20.1	PT Salaried	13.0	14.4
PT Self-Employed	18.7	18.7	PT Self-Employed	13.6	9.0
Supervision & Coor. (n=1861)			**Consultation** (n=994)		
FT Salaried	13.9	13.2	FT Salaried	7.9	8.1
FT Self-Employed	18.1	11.5	FT Self-Employed	8.7	8.9
PT Salaried	12.0	12.0	PT Salaried	12.2	11.4
PT Self-Employed	10.5	11.5	PT Self-Employed	14.7	10.2
Teaching (n=922)			**Time w/ Students** (n=938)		
FT Salaried	11.7	12.0	FT Salaried	---	8.3
FT Self-Employed	6.6	5.8	FT Self-Employed	---	5.0
PT Salaried	13.9	12.5	PT Salaried	---	7.3
PT Self-Employed	10.0	8.7	PT Self-Employed	---	5.5

The percentage of time devoted to various activities was crosstabulated with primary position as well. With the exception of respondents employed in academic settings, the largest percentage of time was devoted to direct patient care. As anticipated, clinical staff devoted the largest proportion of time to this responsibility. Members whose position title implies that they have additional administrative responsibilities also devoted a substantial amount of time to patient care. Sole owners or partners in private physical therapy practices devoted substantial portions of their time to direct patient care as well.

Responses to this item pointed out the diversity of activities among the membership. For example, academic administrators devoted, on average, more than one-fourth of their time (26.4%) to direct patient care. Conversely, clinicians devoted a substantial portion of their time to teaching and research. For example, sole owners of private practices indicated that they spent, on average, more than 12 percent of their time teaching or conducting research. These findings were consistent with those of earlier studies.

Mean Percentage of Time Devoted to Activities by Primary Position

Primary Position	Care		Administration		Supervision		Teaching	
	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %
Owner/Pres. of Prac/Business	70.2	67.0	17.8	19.4	9.8	11.8	7.6	6.3
Partner in Prac/Business	66.8	66.7	20.6	20.7	11.0	11.6	7.1	5.0
Clinical Admin/Director	51.3	47.3	32.3	39.9	15.5	13.6	6.5	7.1
Academic Admin/Director	21.7	26.4	52.5	35.4	14.1	5.9	25.5	38.0
Clinical Supervisor Coordinator	59.9	58.1	16.0	20.1	19.2	16.6	8.1	7.5
Academic Faculty	14.7	25.4	21.3	22.4	19.6	9.4	53.9	46.4
Staff PT	---	78.4	---	11.7	---	11.7	---	6.7
Senior Staff PT	---	71.1	---	12.4	---	10.6	---	6.9
Clinical Staff	79.4	---	10.5	---	9.5	---	7.4	---
Other	64.9	66.1	28.8	34.5	13.7	12.2	11.4	9.7

Table continued on next page

Mean Percentage of Time Devoted to Activities by Primary Position (Cont.)

Primary Position	Consultation		Screening/Prev.		Research		Time with Students	
	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %
Owner/Pres. of Prac/Business	9.0	9.5	6.4	5.7	5.5	6.0	---	5.0
Partner in Prac/Business	9.0	7.0	5.8	5.2	5.7	4.9	---	5.1
Clinical Admin/Director	6.4	7.6	5.7	6.0	4.4	5.0	---	5.7
Academic Admin/Director	6.1	5.7	16.0	5.0	9.4	18.4	---	13.9
Clinical Sup/Coordinator	8.1	8.5	5.6	6.4	5.6	4.8	---	8.3
Academic Fac.	7.8	10.1	3.5	7.3	18.1	18.9	---	18.3
Staff PT	---	9.3	---	6.9	---	5.9	---	6.7
Senior Staff PT	---	7.6	---	6.0	---	5.0	---	8.2
Clinical Staff	8.3	---	6.1	---	6.1	---	---	---
Other	18.7	12.1	8.1	8.7	22.7	17.2	---	7.8

*Note that percentages do not add to 100% as they are computed on different sub-samples.

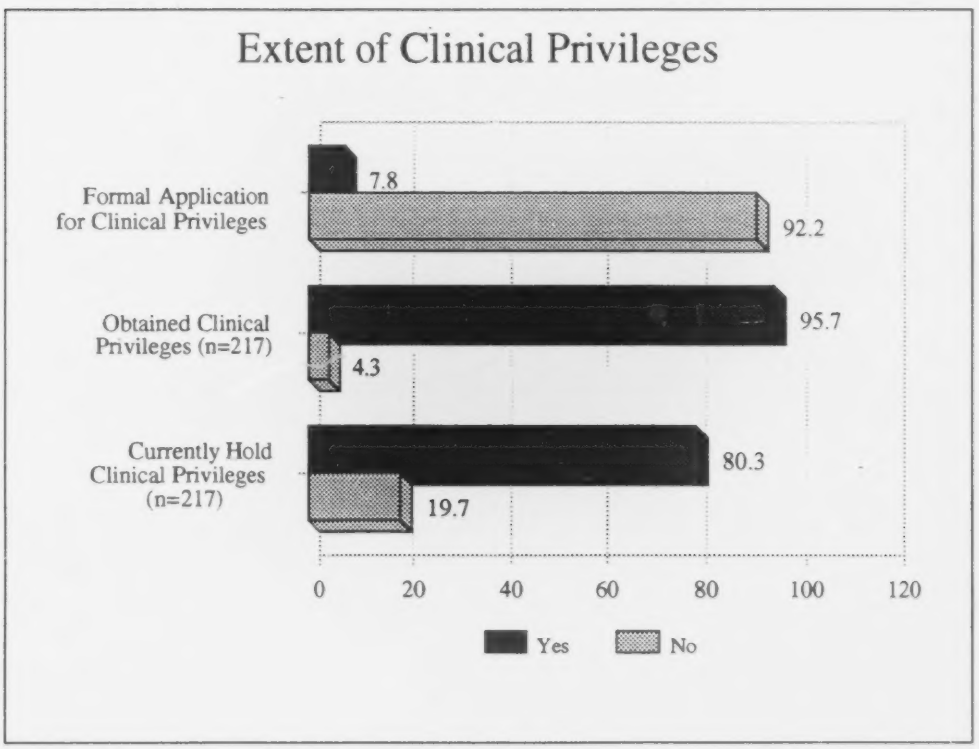
Clinical Privileges

Clinical privileges, which are currently referred to as "practice privileges," have been defined by the APTA Task Force on Practice Privileges as:

> Authorization by the governing body to provide specific patient care and treatment services in the organization, within well-defined limits, based on an individual's license, education, training, experience, competence, and judgement. The privileges may encompass the full scope of physical therapy practice as defined by state law or be limited to a specific clinical service or patient population.[5] (1991)

Although practice privileges represents an area for attention by the profession, the number of physical therapists who have been affected by this issue remains extremely small. Less than one of ten survey respondents (7.8%) indicated that they had formally applied for practice privileges. Further, for a number of respondents who stated that they had applied for practice privileges, it appears that they misinterpreted the meaning of this issue. This group of respondents were physical therapists employed in hospital settings who may have interpreted the ability to provide direct patient care in their setting as being synonymous with practice privileges.

More than nine of ten individuals who had applied for practice privileges (n=200) were, in fact, granted these privileges. Further, 80.3 percent (5.5 % of all survey respondents) of those members who had applied for practice privileges had retained these privileges.



Involvement in Research

There was a continuing increase in member involvement in research as compared to previously collected data. This included a slight increase in the percentage of respondents who designed or conducted their own research studies or read and discussed research reports. Since 1990, there was no change in the percentage of respondents who had some other involvement in research Further, there was a decrease in the percentage of respondents who indicated that they had no involvement in work-related research.

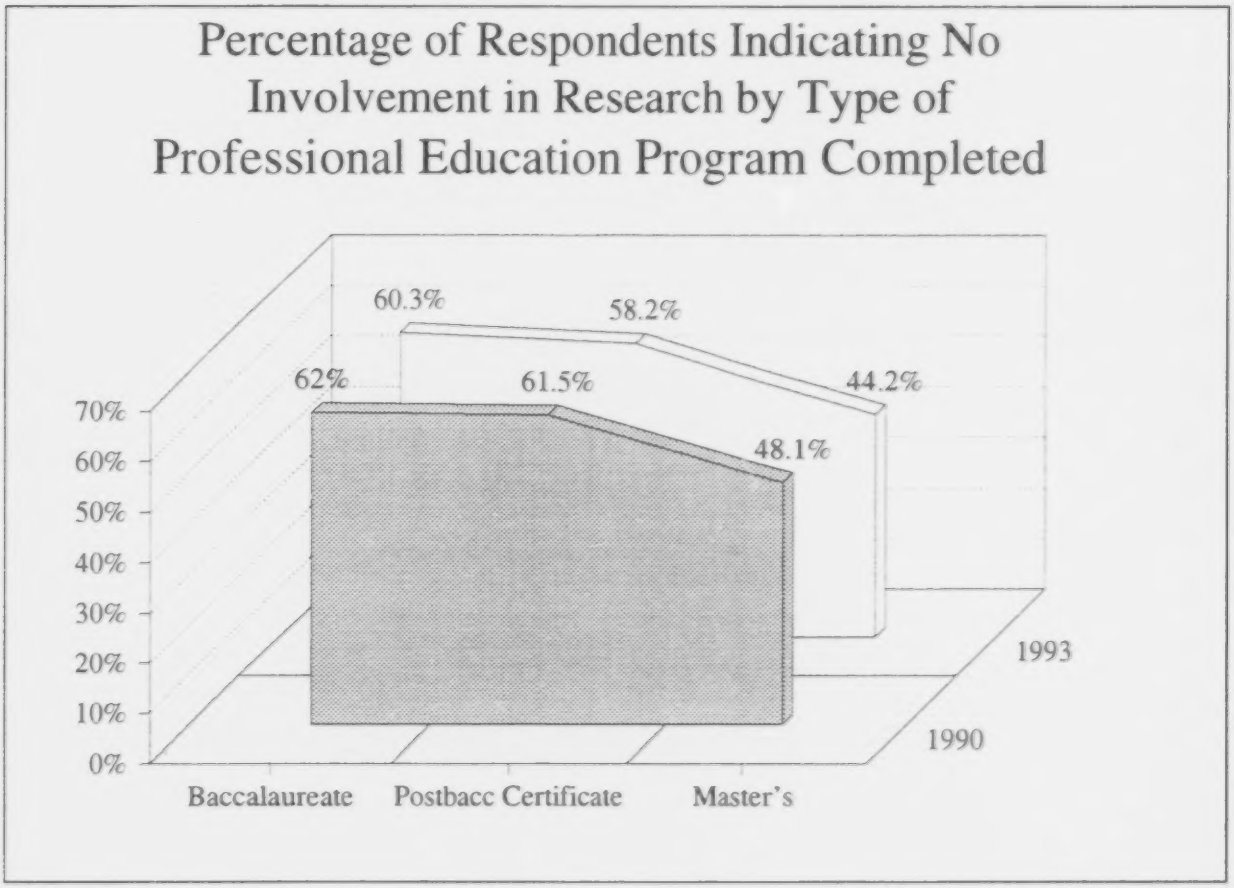
Work-Related Involvement in Research

Type of Involvement	1987 %	1990 %	1993 %
Design, conduct, and report research	4.6	6.7	6.9
Assist in designing, conducting, or reporting research	7.3	N/A	N/A
Provide support (time, funding) for research	5.8	N/A	N/A
Read and discuss reports of research	25.8	27.9	31.6
Other involvement in research	3.8	7.7	7.7
No involvement in research	66.2	60.7	57.9

When work-related involvement in research was crosstabulated by gender, there was a slightly greater tendency for men than women to be involved with research. However, this difference appears to have changed since the last Profile was conducted. In 1990, nine percent of the men stated that they had designed and conducted their own studies, while only 5.9 percent of female respondents reported this level of involvement. This year, the percentage of men who indicated that they had designed and conducted their own research decreased to 8.3 percent, while the corresponding percentage of women who had designed and conducted their own research increased to 6.4 percent.

On the other hand, the percentage of respondents, by gender, who stated that they had no involvement in research was distributed differently than in 1990. Women had been slightly less likely than men (60.4% versus 61.2%) to have no involvement in research in 1990. This year, although the likelihood of having no involvement in research decreased for both sexes, women were now more likely than men (59.9% versus 52.3%) to have had no involvement in research.

Differences were evident when involvement with research was analyzed based on type of professional degree earned by respondents. Before citing these differences, however, it must be noted that there were substantial differences in the numbers of respondents who had earned the various types of professional degrees. These differences will be discussed more fully in the next section of the report. With this caveat, it appeared that graduates of master's degree professional education programs were much more likely to design and conduct research than were their counterparts who had graduated from baccalaureate degree professional programs. Further, those graduates of master's degree professional programs were much less likely to have had no involvement with research. These results replicated findings from the 1990 Profile. Thus, the link between postbaccalaureate degree professional education and the likelihood a respondent would conduct research has been reaffirmed.



EDUCATIONAL INFORMATION

Professional Education

As found in previous profiles, the majority of the membership had graduated from a bachelor's degree program. In fact, the percentage of graduates from these programs has increased since the 1990 survey. The percentage of graduates from master's degree programs has increased since 1990 as well. These findings continued a trend that has been noted since the survey was initiated. This increase in the percentage of graduates of bachelor's and master's degree programs was, obviously, accompanied by a decline in the proportion of members who completed a postbaccalaureate certificate as their professional degree.

Type of Entry-Level Program Completed

Entry-Level Program	1983 %	1987 %	1990 %	1993 %
Baccalaureate Degree	72.7	74.3	75.4	77.1
Postbaccalaureate Degree	20.6	17.1	14.3	12.2
Master's Degree	4.5	6.7	8.8	9.5
Other	2.2	1.8	1.5	1.2

Type of Entry-Level Education Program Completed by Gender of Respondent

Type of Program	Female			Male		
	1987 %	1990 %	1993 %	1987 %	1990 %	1993 %
Baccalaureate	78.2	79.5	79.2	63.2	63.5	71.8
Postbaccalaureate	13.9	10.6	10.6	26.7	24.5	16.1
Master's	6.0	8.5	9.1	8.9	10.3	10.7
Other	1.9	1.4	1.1	1.2	1.7	1.4

Differences were noted among respondents when crosstabulations of level of professional program and gender were completed. Male respondents were more likely to have graduated from a certificate or master's program than were female respondents, although the difference in the likelihood of graduating from a master's degree program between men and women decreased since 1990.

The difference in the likelihood of graduating from a baccalaureate degree program continued to be related to gender, although not to the same extent found among 1990 respondents. Nearly four of every five female respondents (79.2%) had graduated from a bachelor's degree program, while 71.8 percent of the male respondents were graduates of baccalaureate degree professional education programs.

Slight differences were evident when type of professional program completed was analyzed by race or ethnic origin of members. When considering these differences, however, it is important to note that there were large variations in the number of respondents among the race or ethnic categories. That is, there were small numbers of respondents from minority race or ethnic groups.

Asians were the most likely group to have earned a master's degree. Hispanics or American Indians were the most likely ethnic groups to have completed a bachelor's degree professional education program. In fact, none of the Hispanic respondents to the current membership profile indicated that they had earned a master's degree. Among Hispanics who responded to the 1990 survey, the percentage of master's degree recipients was 4.7 percent. There are two possible explanations for this decline. The first is that, in fact, no Hispanics have enrolled in and

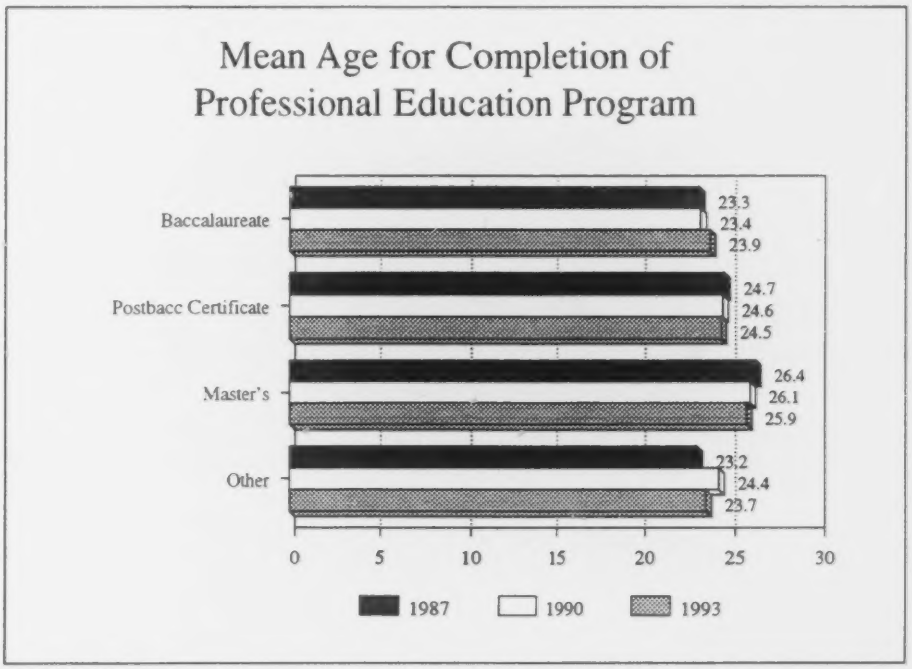
Respondents by Professional Education Program Completed and Race or Ethnic Origin

Degree	Asian		Black		Caucasian		Hispanic		American Indian	
	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %
Baccalaureate	73.3	60.4	76.7	77.4	75.3	77.4	82.2	83.0	83.3	100.0
Postbaccalaureate	10.9	14.0	14.0	19.4	14.4	12.3	8.9	14.9	16.7	--
Master's	15.8	23.3	4.7	---	8.7	9.1	6.7	---	--	--
Other	---	2.3	4.7	3.2	1.5	1.2	2.2	2.1	--	--

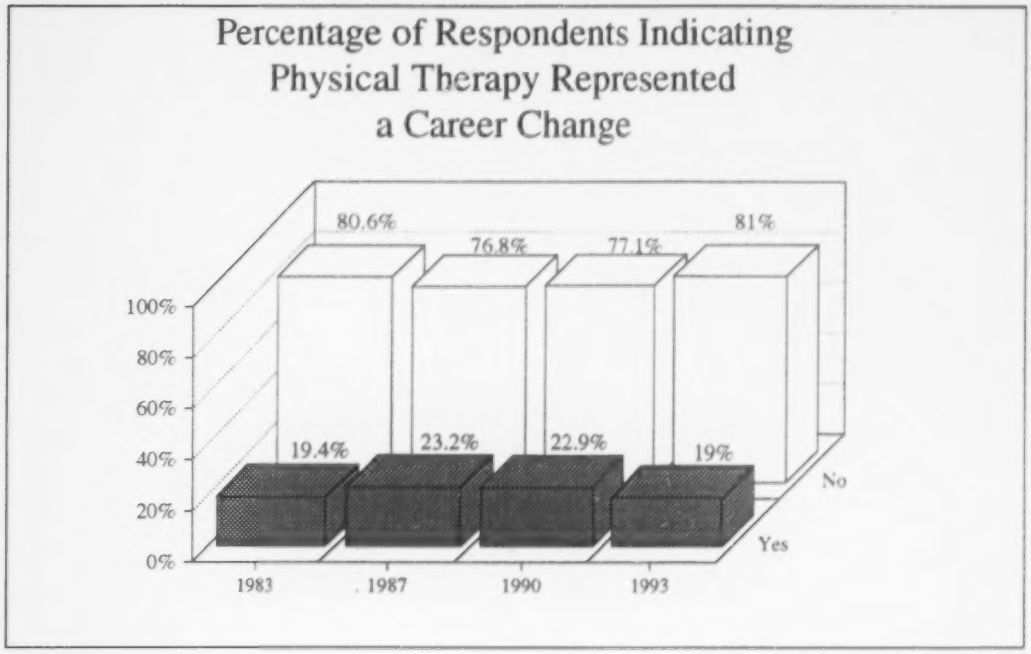
completed a master's degree professional education program. The second, and more likely, explanation, is that because there was a small number of Hispanic respondents to both surveys, the fact that no Hispanics reported that they had graduated from a master's program may have been due to sampling error, and the finding should not be generalized to the entire membership.

The mean age at which professional education was completed was 24.1 years, up slightly from the 1990 data. Men tended to be slightly older than women when they completed their professional program. The mean age for completion reported by men was 25.4; for women, it was 23.7.

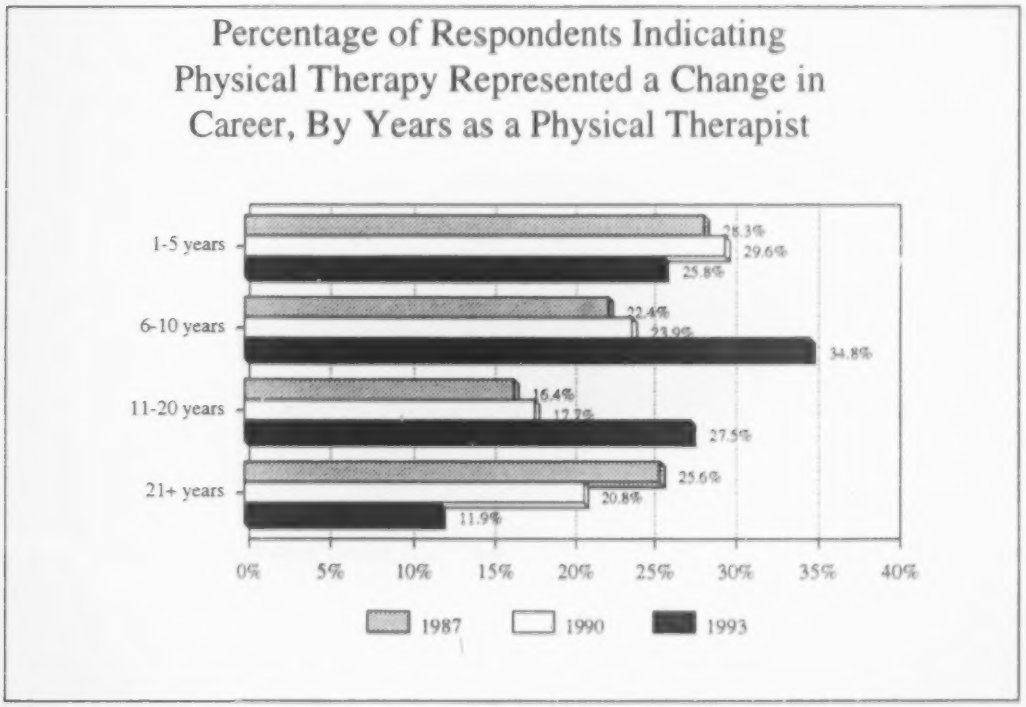
Differences were found among graduates of the various levels of professional education programs. Graduates of baccalaureate degree professional programs were, on average, two years younger than were graduates of master's degree programs. In comparison to the 1990 profile, the mean age at completion of program was essentially the same, regardless of earned degree.



Although it declined slightly, the percentage of respondents who indicated that physical therapy represented a career change remained similar to the proportion of respondents from previous surveys. Slightly less than one of every five members (19.0%) from the most recent survey believed that entrance into the profession represented a change in career. This percentage represents a slight decrease since 1990. In fact, it is the lowest percentage reported since data were first collected in 1983.

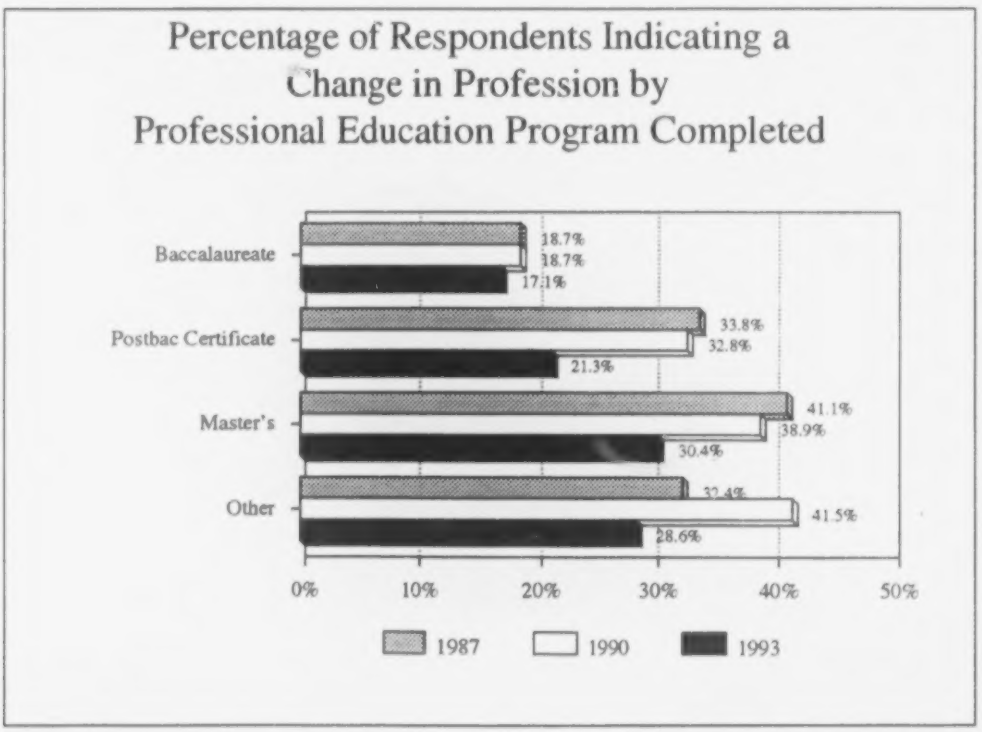


The distribution of respondents who believed that entrance into physical therapy represented a career change shifted substantially since 1990. Newer physical therapists (those practicing five years or less) had been more likely to change careers. However, among respondents to the current survey, the group most likely to have changed career was comprised of physical therapists who had been practicing from 6 to 10 years.



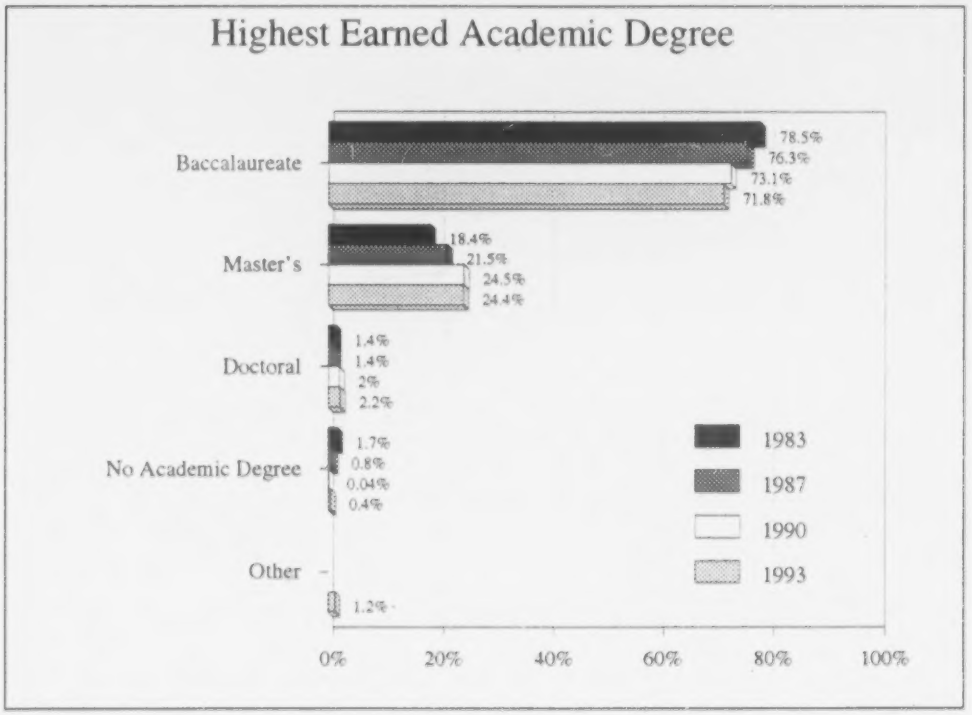
Two of the four groups of respondents, based on years of experience established by the researcher, were equally likely to indicate that physical therapy represented a new career. Those practicing for 6 to 10 years were substantially more likely to have changed careers; those respondents practicing for more than 20 years were substantially less likely to have changed careers.

There were clearly differences in the type of professional degree earned and the belief that entrance into physical therapy represented a career change. A substantially larger percentage of graduates of master's degree programs indicated that physical therapy represented a new career in comparison to graduates of baccalaureate programs. This is not a surprising finding, for it is more likely that an individual who was pursuing a career had earned, minimally, a bachelor's degree for entrance into his or her previous profession. Thus, the individual would be more likely to opt for a master's degree upon returning to school. As physical therapy programs have recently begun to award the master's degree as the professional degree, the relationship between career change and degree level found among more recent graduates was an expected finding. Although this expected result was obtained, it is important to note that the percentage of respondents who indicated a career change declined in each level of earned degree.



Highest Earned Academic Degree

Respondents were as likely as their counterparts in 1990 to continue their education beyond the bachelor's degree. The percentage of members who stated that the bachelor's degree was their highest earned degree decreased slightly, continuing a pattern that has been noted since the survey was begun. The percentage of members who had not earned a graduate degree has declined consistently since 1978. This, too, is an expected finding, as more physical therapist professional education programs have made the transition to postbaccalaureate professional education and more master's degrees have been awarded.



This trend exists regardless of gender. Both men and women were less likely to have earned a baccalaureate degree; and men were more likely than women to have earned a graduate degree. The percentage of either master's or doctoral degree recipients was higher among male respondents.

Highest Earned Degree By Gender*

Gender	Bachelor's			Master's			Doctoral		
	1987 %	1990 %	1993 %	1987 %	1990 %	1993 %	1987 %	1990 %	1993 %
Female	78.7	74.6	73.7	19.9	23.5	23.3	0.8	1.5	1.5
Male	69.7	68.0	66.1	26.1	28.0	27.1	3.1	3.4	4.2

*The "other" and "no degree" categories were not included in the table.

When highest earned degree was crosstabulated based on race or ethnic origin, slight differences were found among groups. Once again, a cautionary note must be added to these reported data. With the exception of Caucasians, race or ethnic groups were characterized by a very small number of respondents. Some of the reported differences are likely a function of these rather small numbers.

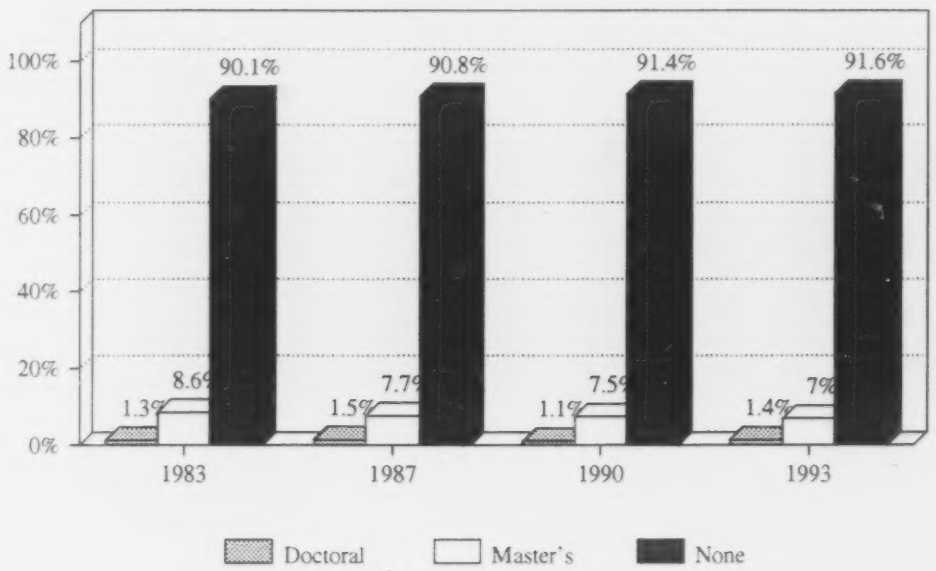
Highest Earned Academic Degree by Race or Ethnic Origin*

Race or Ethnic Origin	Bachelor's		Master's		Doctoral	
	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %
Asian	69.3	64.0	26.7	32.6	4.0	1.2
Black	62.8	61.3	30.2	32.3	7.0	6.5
Caucasian	73.3	72.1	24.4	23.9	1.9	2.1
Hispanic	77.8	68.1	17.8	29.8	4.4	2.1
American Indian	66.7	72.7	33.3	--	--	27.3

*The "other" and "no degree" categories were not included in the table. Consequently, percentages do not add to 100%.

Current Enrollment in Postprofessional Graduate Study

The pattern of enrollment in postprofessional education programs has changed slightly when compared to 1990. The percentage of members enrolled in master's degree programs has declined slightly. This decline can likely be explained by the increase in the percentage of the membership that has graduated from a master's degree professional education program. Likewise, the percentage of members enrolled in doctoral programs increased slightly.



Enrollment in Postprofessional Education Program By Gender

Degree	Female			Male		
	1987 %	1990 %	1993 %	1987 %	1990 %	1993 %
Doctoral	1.2	1.0	1.1	2.2	1.6	2.0
Master's	8.2	7.8	7.2	6.3	6.3	6.3
None	90.6	91.2	91.7	91.4	92.1	91.7

When enrollment in postprofessional education programs was studied based on the gender of respondents, there was little difference between men and women. Slightly more than 8 percent of respondents from either sex were currently enrolled in postprofessional graduate education programs. However, there were differences in the level of program in which respondents were enrolled. A slightly larger percentage of men was currently enrolled in doctoral programs, while a larger percentage of women was enrolled in master's degree programs.

When enrollment was analyzed by ethnic origin, some differences were found both in comparison to 1990 data and among ethnic groups. Since 1990, the percentage of members enrolled in doctoral programs has increased among Asians. The percentage of postprofessional master's degree students increased among Native Americans and Hispanics. The number of Caucasian respondents enrolled in master's programs decreased slightly, while those in doctoral programs increased slightly. However, Caucasians remained the most likely group to be enrolled in postprofessional master's degree programs. Again, it is extremely important to remember that the numbers of minority group members responding to the survey were quite small.

The likelihood of current enrollment in a postprofessional graduate program appeared to be related to the type of professional program attended by the respondent. Graduates of baccalaureate programs were much more likely to be enrolled in a postprofessional master's degree program. Graduates of professional master's degree programs, however, were more likely to be enrolled in a

Current Enrollment in Postprofessional Education Program by Race or Ethnic Origin

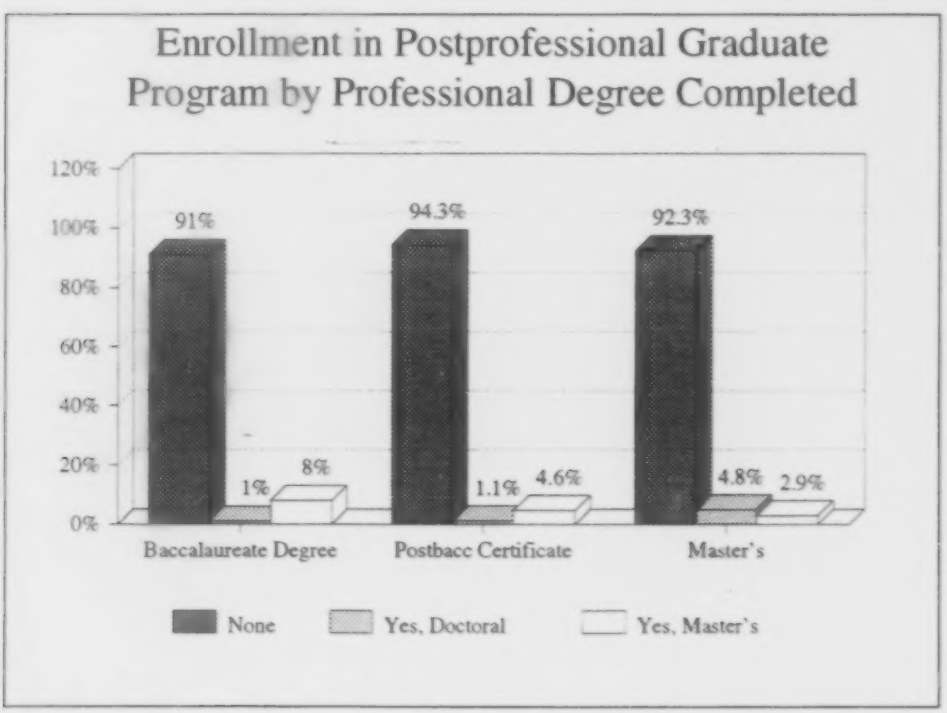
Race or Ethnic Origin	Yes, Doctoral		Yes, Master's		No	
	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %
Asian	2.0	2.3	5.0	3.5	93.0	94.2
Black	--	--	7.0	---	93.0	100.0
Caucasian	1.1	1.3	7.5	7.2	91.4	91.5
Hispanic	2.2	---	2.2	6.4	95.6	93.6
American Indian	5.6	---	16.7	18.2	77.8	81.8

doctoral program than were graduates of other types of professional education programs. This finding suggests that further study must be made on the question of the relationship between the transition to postbaccalaureate degree professional education and enrollment in postprofessional graduate programs. It is important for the profession to determine whether postbaccalaureate degree professional education inhibits enrollment in a postprofessional master's degree program or whether the two types of graduate education are complementary. This is a meaningful research question that warrants additional study.

Enrollment in Postdoctoral Education

Respondents were asked if they were enrolled in a postdoctoral program. This was the second time this question was asked of members. Only six respondents (0.2% of the membership) were enrolled in these programs in 1993. This was the same percentage that reported enrollment in a postdoctoral experience in 1990.

The Association realizes that research and the expansion of the scientific base of the profession is a priority. One method for increasing the research competence of the membership is to increase the number of members involved in postdoctoral experiences. It is, therefore, an objective of the Association to increase substantially the number of postdoctoral scholars in the future.



Continuing Education

Members continue to be increasingly more involved in continuing education opportunities. The percentage of respondents who either did not respond to this item or indicated that they did not complete any continuing education offerings in 1992 decreased substantially in comparison to previous surveys. Further, although the percentage remained quite small, there was an increase in the percentage of members who enrolled in ten or more courses. As the APTA expands its efforts in the areas of professional development and continuing education, additional research should be conducted to determine the types of continuing education offerings in which members have enrolled.

The mean number of continuing education courses completed in 1989 was 3.77, an increase of nearly one course per member when compared to respondents to the previous survey. On average, men completed more courses than women. Female respondents completed an average of 3.66 courses, while men completed an average of 4.11 courses.

The mean number of courses completed by graduates of baccalaureate and master's degree professional education programs was essentially identical (3.13 and 3.09, respectively). Both these statistics were higher than those reported in 1990. Both these means were lower than the mean number of continuing education courses completed by graduates of postbaccalaureate certificate programs (4.00) and "other" (presumably international) programs (3.68). These findings continue a pattern noted in the 1990 Membership Profile.

Number of Continuing Education Courses Completed

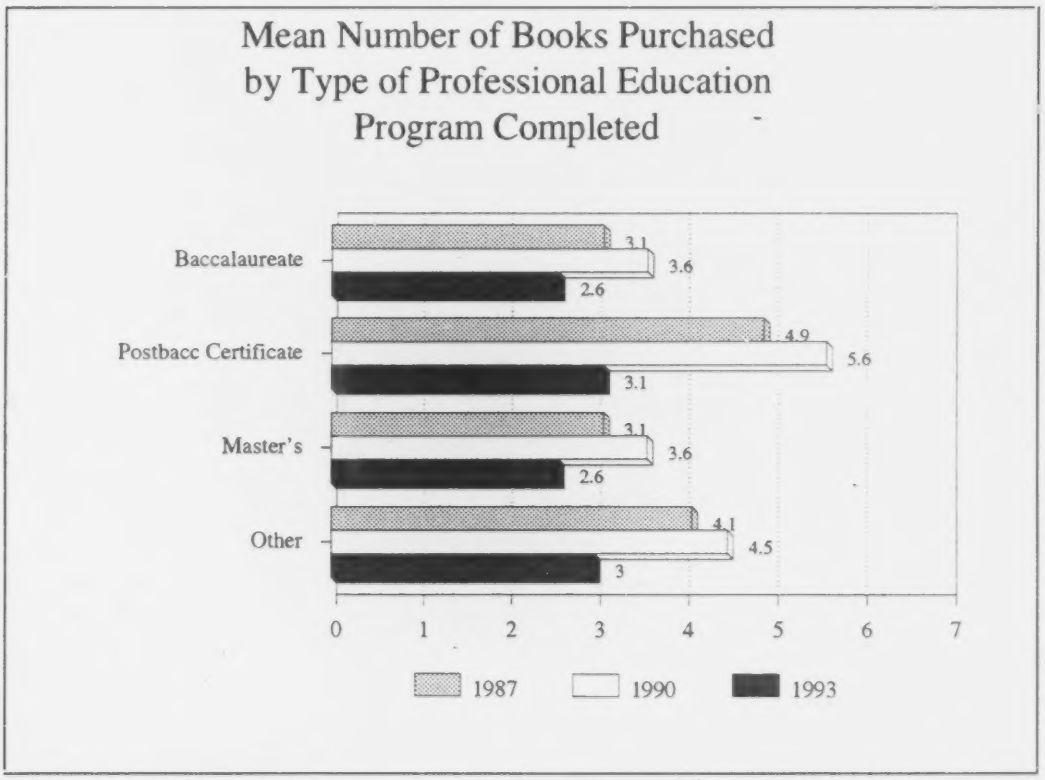
Number of Courses	1982 %	1986 %	1989 %	1992 %
None/No Response	14.3	18.3	12.5	6.5
1-3	65.2	64.4	67.6	71.0
4-6	17.0	14.8	17.3	18.6
7-9	2.1	1.8	1.2	1.5
10 or more	1.3	0.8	1.4	2.4

Purchase of Books

In comparison to previous studies, respondents purchased substantially fewer books. Typically, one to two books per year were purchased, which was similar to the book purchase pattern found among respondents to previous surveys. However, the percentage of respondents who purchased more than five books declined dramatically.

The overall mean number of books purchased during 1992 was 2.7, a decrease of slightly more than one book when compared to 1989, as reported in the 1990 Membership Profile. The mean number of books purchased by female active members was 2.4. The mean number purchased by male respondents was 3.5. Both these statistics were decreases from the means reported in the 1990 Membership Profile.

The mean number of books purchased seemed to be related to the number of years that respondents had practiced. New therapists (those practicing for one year or less) purchased the most books. More experienced therapists (those practicing 11 years or more) also tended to purchase more books than respondents who had been practicing between 2 and 10 years.



Graduates of postbaccalaureate certificate programs purchased, on average, more books than their colleagues who graduated from programs at other levels. However, these mean differences in the number of books purchased were small.

Professional and Scientific Books Purchased

Number of Books	1982 %	1987 %	1990 %	1993 %
None/Missing	19.8	20.2	23.7	22.9
1 - 5	33.3	35.8	23.7	66.8
6 - 10	30.2	29.6	27.0	8.4
11 - 15	3.4	1.6	1.9	1.2
16 - 19	0.2	0.1	---	0.1
20 or more	1.5	1.8	1.0	0.6

Attendance at Scientific Meetings

The mean number of scientific meetings attended by active members was 1.5, a decline from the 3.5 meetings reported by respondents in 1990. There were slight differences noted in meeting attendance by gender: female respondents attended 1.6 meetings; male respondents attended 1.5.

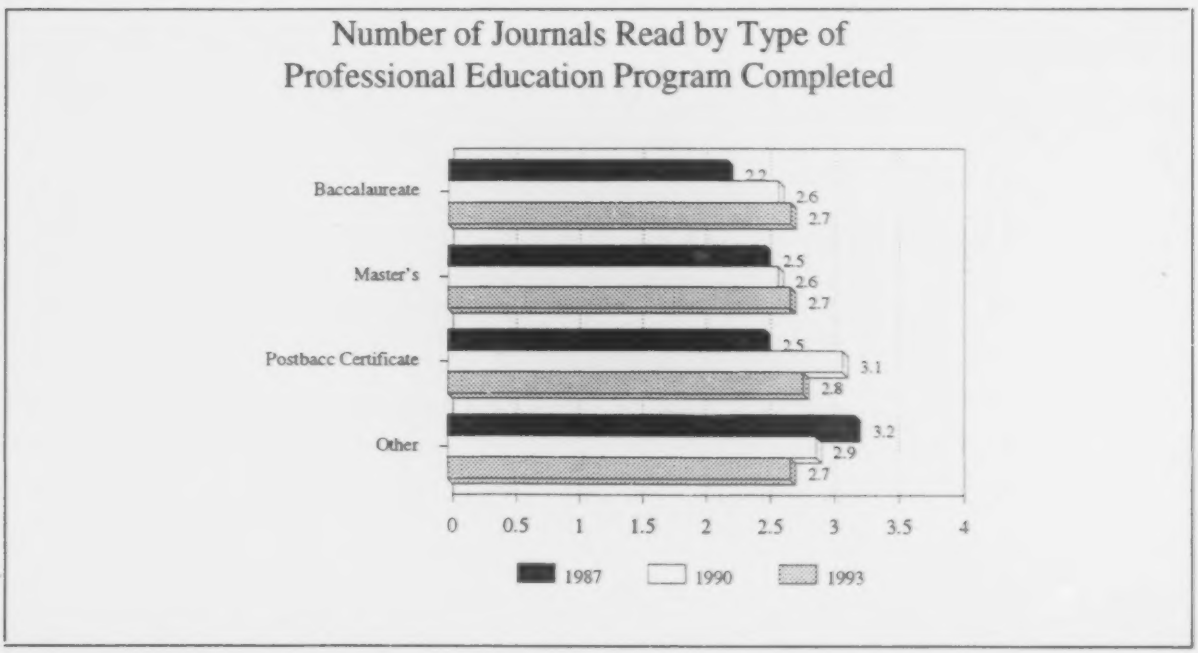
Members practicing for five years or fewer attended more meetings than did members who had practiced longer. However, the difference in meeting attendance between this group of newer therapists and the rest of the membership was very slight.

When number of meetings attended was analyzed based on the type of professional education program completed, the results were anticipated. Graduates of master's degree professional education programs attended, on average, more scientific meetings than did graduates of baccalaureate programs (1.7 and 1.5 meetings, respectively). These results, however, reverse a finding from the 1990 Membership Profile. Currently, the mean number of meetings attended by graduates of postbaccalaureate certificate programs was 1.4.

Journal Subscriptions

The number of professional or scientific journals read by active members was very similar to that reported in 1990. The modal number of journals read by members was two, as it had been in 1990. The percentage of members who read only one journal has decreased consistently since 1978. The percentage of respondents who typically read four or more journals has continued to increase, from 11.8% in 1983 to 24.8% in 1993. Overall, the mean number of journals read by active members increased from 2.7, as reported in the 1990 Active Membership Profile, to 2.8. Although the responses were similiar to 1990, changes have been noted since data were first collected.

Male respondents read more journals than did female respondents. The mean number of journals read by men was 3.4; among women, the mean number was 2.6. There did not appear to be any systematic variance in the number of journals read based on the number of years members had been physical therapists. Those who had been in practice more than 20 years read, on average, more journals ($\bar{X}$=3.0). However, this figure was not substantially more than the mean number of journals read by members who had been practicing for shorter periods of time. There was essentially no difference in the number of journals read by graduates of baccalaureate and master's degree professional education programs. The mean number of journals read was 2.8 for graduates of baccalaureate programs and 2.7 for graduates of master's degree professional education programs. Graduates of postbaccalaureate certificate programs read, on average, the greatest number of journals ($\bar{X}$=2.8).



Number of Professional and Scientific Journals to Which Respondents Subscribe

Number of Journals	1983 %	1987 %	1990 %	1993 %
None/No Response	--	--	--	2.3
1	35.1	28.9	22.8	19.2
2	33.9	34.0	28.7	28.5
3	18.2	21.6	22.7	25.2
4-5	10.9	11.9	18.2	19.3
6-8	0.6	0.6	4.4	4.9
9-13	0.1	---	0.6	0.4
14-19	0.1	---	0.1	0.2
20 and up	0.1	0.1	---	---

Knowledge of Research Design and Methods

The expansion of research productivity continues to be a major initiative for the profession. Thus tracking research activity among the membership has taken on added importance. The percentage of active members who indicated that they have sufficient methodology and design skills enabling them to read journal articles has remained the same since 1990. Half the respondents to the survey continued to believe that their knowledge of research design and methodology permitted them to read critically and evaluate research reports published in scholarly journals.

There were substantial differences in perceived knowledge of research methodology based on the type of professional program from which the respondent had graduated. Nearly three of every four graduates of master's degree professional education programs (73.2%) felt that they had the requisite knowledge to read critically and evaluate scientific literature. However, this was a decline in the percentage of master's degree recipients who had confidence in their knowledge of research design. Conversely, less than half (48.7%) of respondents who had graduated from baccalaureate programs felt that they were prepared to evaluate research studies.

Sufficient Working Knowledge of Research Design and Methods by Type of Professional Program Completed

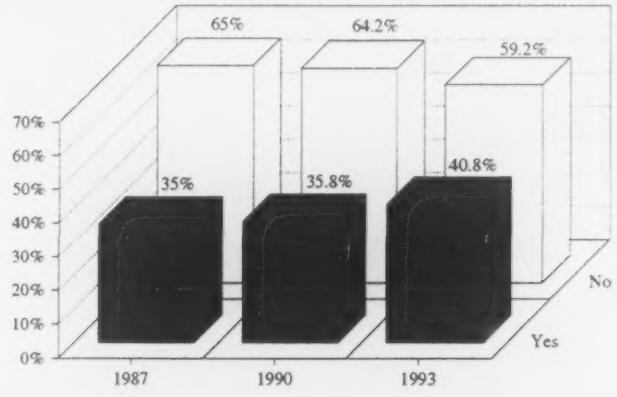
Professional Program	Yes		No		Don't Know	
	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %
Baccalaureate	47.7	48.7	35.7	35.7	16.6	15.6
Postbaccalaureate	45.9	49.9	35.8	35.5	18.2	14.6
Master's	80.6	73.2	13.7	18.4	5.7	8.4

Specialization

The percentage of active members who believe that they will achieve formal certification in a clinical specialty has increased since 1990. This percentage remains less, however, than the proportion of members responding to the 1983 survey (the first group asked this question) whose professional plans included certification in a clinical specialty.

The respondents' plans to become a clinical specialist were analyzed based on a number of variables, including gender, race or ethnic origin, type of professional education program completed, highest earned academic degree, and knowledge of research methodology. Men were more likely than women to be interested in specialization; Hispanics were the most likely group

Plans Include Achieving Formal Certification as a Specialist



to be interested in certification (although, as mentioned previously, a small number of race or ethnic minorities responded to the survey); and graduates of master's degree professional education programs were more likely to consider specialization than were graduates of other levels of education programs. When highest earned degree was studied, recipients of doctoral degrees were the least likely candidates for specialization. Those active members who believed that they possessed knowledge about research design and methodology tended to be more likely to consider specialization than did those members who did not feel as comfortable about their knowledge of research.

Plans Include Certification as Specialist by Type of Professional Program Completed

Degree	Yes		No	
	1990 %	1993 %	1990 %	1993 %
Baccalaureate	37.3	41.7	62.7	58.3
Master's	44.7	50.4	55.3	49.6
Postbaccalaureate	23.2	29.9	76.8	70.1
Other	25.9	30.3	74.1	69.7

Plans Include Certification as Specialist by Sufficient Working Knowledge of Research Design and Methods

Knowledge of Research Design and Methods	Yes		No	
	1990 %	1993 %	1990 %	1993 %
Has knowledge	41.6	47.5	58.4	52.5
Lacks knowledge	27.4	34.2	72.6	65.8
Not sure they have enough knowledge	35.0	34.1	65.0	65.9

Plans Include Certification as Specialist by Highest Earned Academic Degree

	Baccalaureate		Master's		Doctoral	
	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %
Yes	36.1	41.6	36.1	40.4	22.5	27.4
No	63.9	58.4	63.9	59.6	77.5	72.6

Plans Include Certification as Specialist by Gender

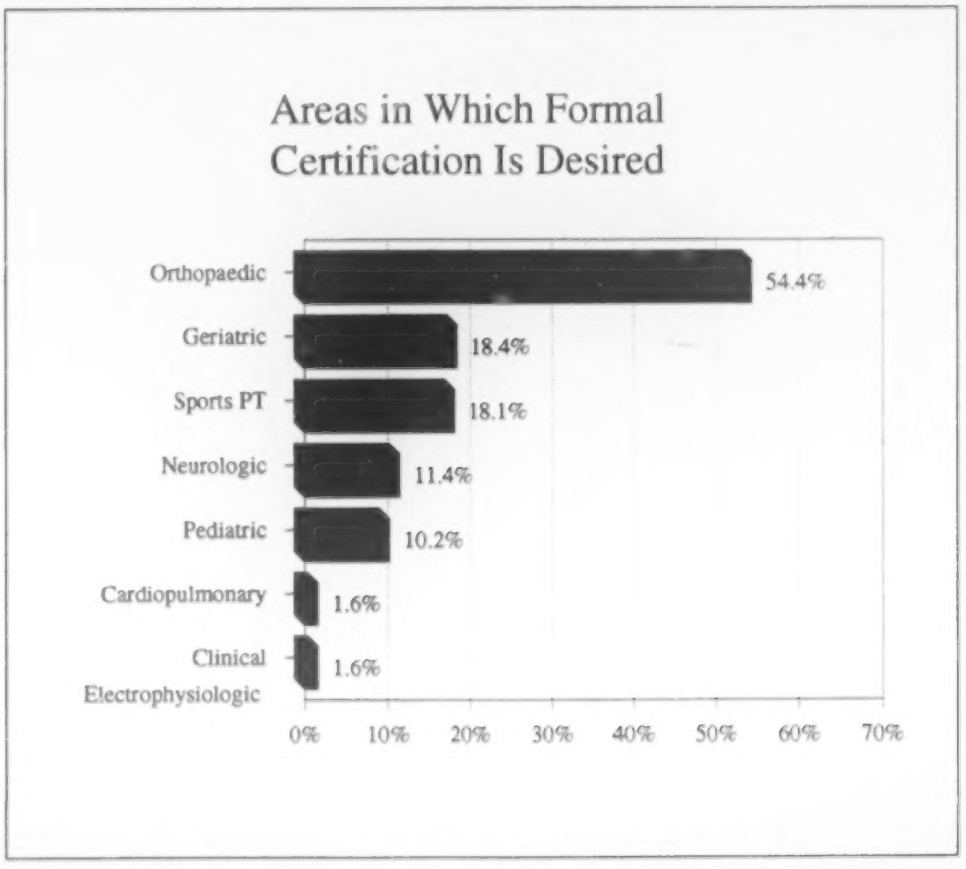
Gender	Female		Male	
	1990 %	1993 %	1990 %	1993 %
Yes	34.3	37.0	39.6	50.9
No	65.7	63.0	60.4	49.1

Plans Include Certification as Specialist by Race or Ethnic Origin

Plan Certification As Specialist	Asian		Black		Caucasian		Hispanic		American Indian	
	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %	1990 %	1993 %
Yes	50.5	50.0	45.2	38.7	35.0	39.9	40.9	66.0	44.4	36.4
No	49.5	50.0	54.8	61.3	65.0	60.1	59.1	34.0	55.6	63.6

Those respondents who indicated that they planned to become certified clinical specialists (n=1,160) were asked in which of the specialty areas they expected to achieve formal certification. Respondents were instructed to cite only one specialty, although it is possible to be certified in more than one area.

Consistent with 1990 data, the largest percentage of members was interested in specializing in orthopaedic physical therapy. More than half the respondents (54.4%) indicated that their interest was in orthopaedics. Geriatrics and sports physical therapy were also popular areas, although not nearly as prevalent as orthopaedics.



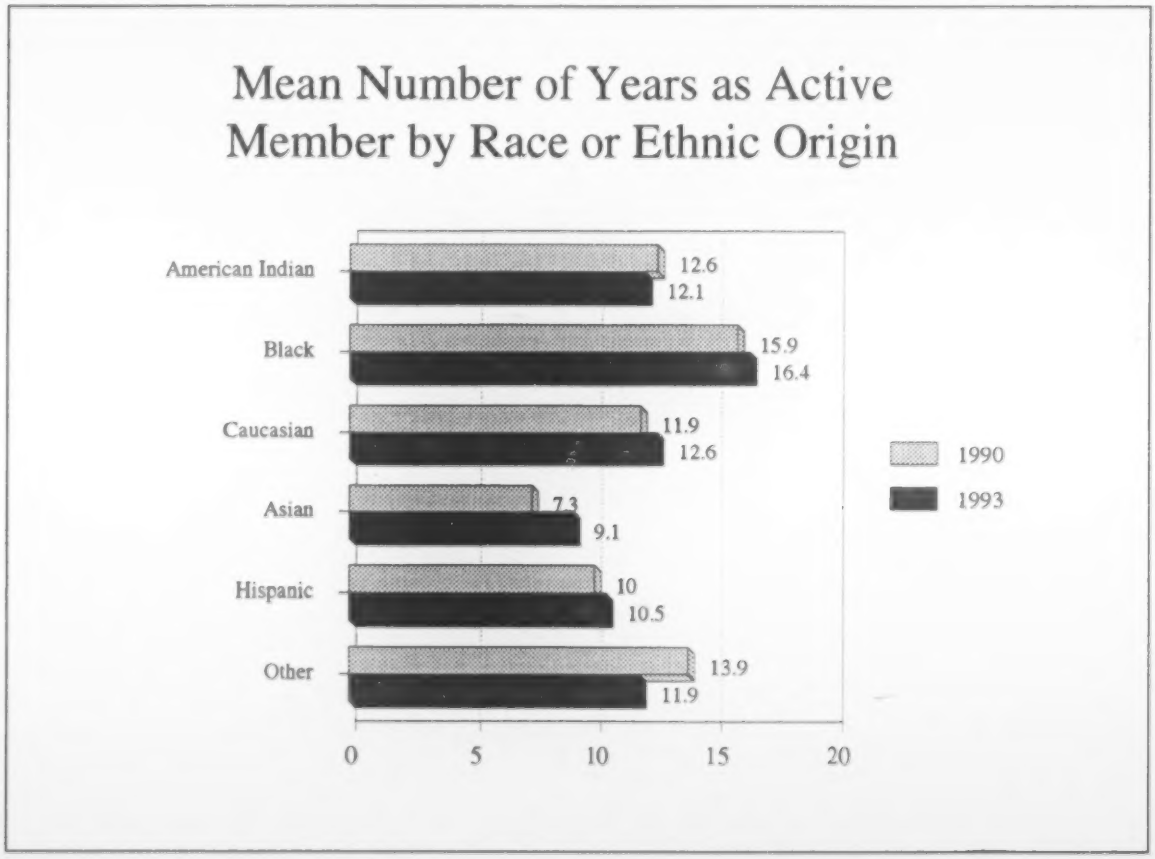
PARTICIPATION IN ASSOCIATION ACTIVITIES

Number of Years as Active Member

The mean number of years of active membership within the Association was 12.5. This is a slight increase from the mean length of membership of 11.9 years reported in 1990. The range of length of membership was from less than one year to 67 years of active membership.

Male respondents had been, on average, members of the Association longer than had female respondents. The mean length of membership among men was 13.0 years, compared with 12.4 years among women.

When length of membership was analyzed based on race or ethnic origin, black respondents had been active members for the longest period of time ($\bar{X}$=16.4 years). Conversely, Asian members had been active members for the least amount of time ($\bar{X}$=9.1 years). Again, caution is needed in interpreting these results due to the small number of minority respondents.



Length of membership was studied based on a number of demographic variables related to employment, including employment status, current position, and the facility in which most of a respondent's practice took place. When employment status was studied, the part-time self-employed member was found to have been a member of the Association for the longest period of time. This result reinforced a finding among 1990 active members. Based on primary position, academic administrators maintained Association membership the longest. When facility was examined, it was found that those members employed in research centers were, on average, members of the Association for the longest period of time. However, there was a very small number of respondents (n=5) from research settings. Among settings with a larger number of respondents, members from academic institutions had been, on average, members of the Association for the longest period of time.

Mean Number of Years as Association Member

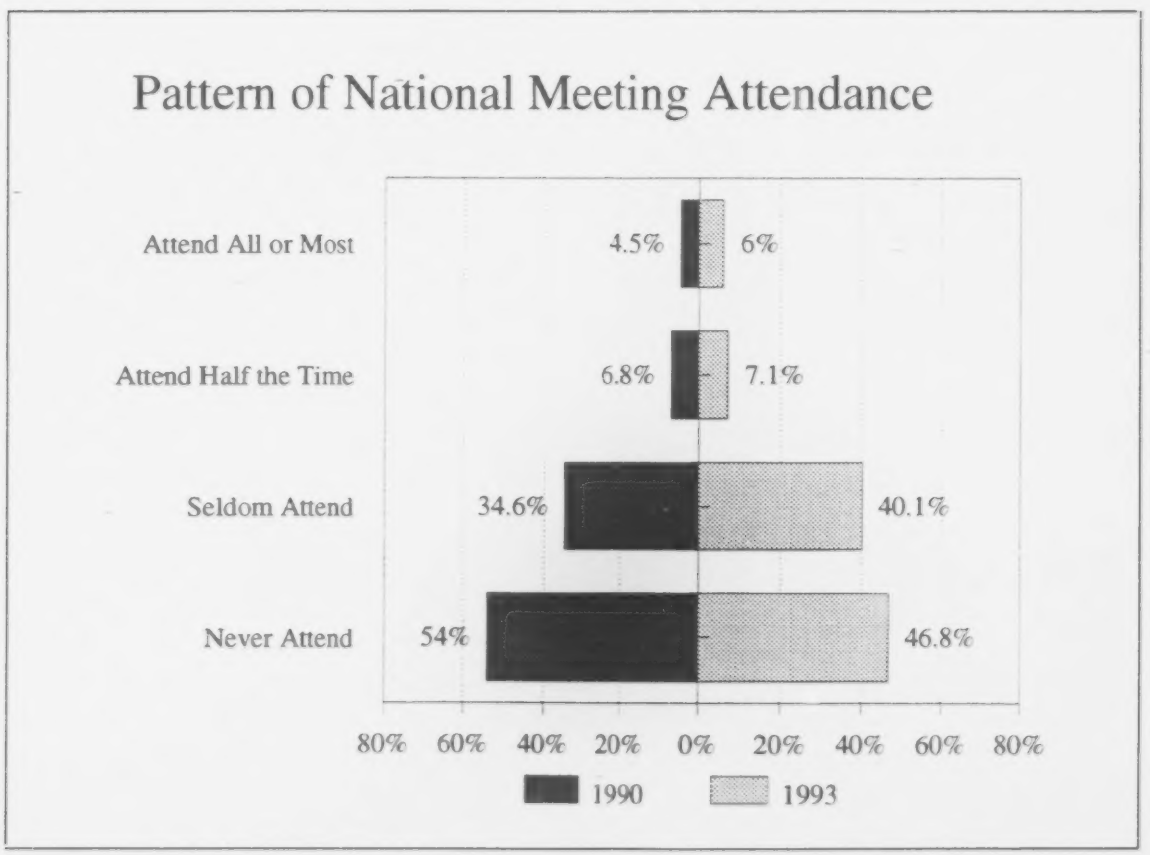
Employment Status	Mean No. of Years	Facility	Mean No. of Years
Full-Time Salaried	11.3	Hospital	11.6
Part-Time Salaried	12 3	Home Health Agency	15.6
Full-Time Self-Employed	15.4	Rehab, Inpatient and Outpatient	9.7
Part-Time Self-Employed	16.3	Rehab, Outpatient Only	9.7
		Extended Care Facility/Nursing Home	13.1
Current Position		Academic Institution	17.0
Owner of Practice	16.4	Research Center	18.8
Administrative/Dir. of PT	13.2	Physician's Office	13.1
Supervisor/Coor. of PT	11.1	Public or Non-Public School (K-12)	14.7
Staff Physical Therapist	9.7	Prepaid Health Care Organization	14.1
Senior Staff Physical Therapist	10.5	Private Physical Therapy Office	12.0
Partner in Practice	13.9	Other	14.1
Academic Administrator	18.6		
Faculty Member	16.3		
Other	15.4		

Reimbursement of Dues

A new question was added to the 1993 Profile that would aid the Association in determining how dues are paid. Salaried employees were asked whether or not they were compensated for dues by their employers. More than half the appropriate respondents (53.5%) indicated that their employer made either partial or full payment of Association dues. These responses will continue to be studied in the future to assess trends in payment of dues.

Attendance at National Meetings

Although the percentage has declined since 1990, the majority of active members has never or seldom attended national meetings. Nearly half the respondents to the survey (46.8%) stated that they have never attended Association-sponsored national meetings. Approximately two of five respondents (40.1%) indicated that they seldom attended national meetings. The percentage of respondents who indicated that they attend all or most national meetings has increased by 1.5 percent since 1990.



When national meeting attendance was analyzed based on selected demographic variables, differences were found. Men were more likely to attend these meetings. Although a large percentage of men (38.4%) has never attended meetings, the corresponding percentage among female active members (49.7%) was substantially higher. Conversely, while only 5.1 percent of the female respondents stated that they attended all or most of the national meetings, 8.4 percent of the men indicated that their pattern was to attend all or most of the meetings. Additional crosstabulations revealed that faculty members and sole owners or partners in private practices were more likely to attend national meetings.

Conversely, clinical staff, who make up the largest proportion of membership, are the most likely group never to have attended a national meeting. Clinical coordinators also rarely attend meetings. Members who are affiliated with academic institutions were the least likely group never to attend a national meeting.

When attendance pattern was studied based on the facility in which respondents primarily practiced, active members from academic settings and private physical therapy offices were most likely to attend all the time. Respondents from extended-care facilities, physicians' offices, public or private schools, and rehabilitation settings were the least likely ever to attend.

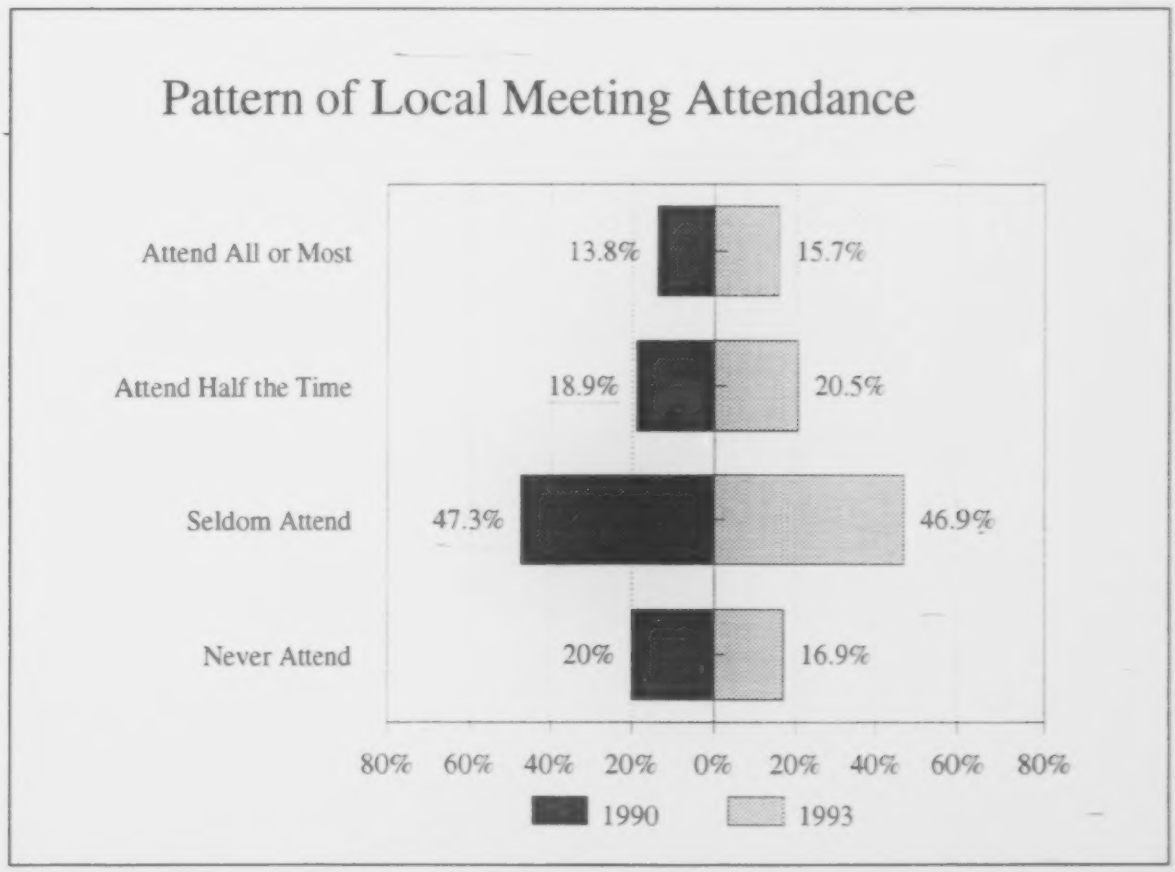
When the data were analyzed based on professional education program completed, differences in patterns of attendance were noted. Graduates of postbaccalaureate certificate programs were the most likely group of active members to attend all or most national meetings. Further, while only 3.6 percent of the baccalaureate program graduates attended all or most meetings, the corresponding percentage of master's degree graduates who attended all meetings was 6.3 percent.

A similar pattern existed when those active members who never attended meetings were studied. Again, graduates of baccalaureate degree professional education programs displayed the least interest in national meetings. While slightly less than half (49.1%) the graduates from baccalaureate programs never attended a national meeting, slightly more than one-third the graduates of postbaccalaureate certificate programs (36.5%) never attended meetings, and approximately two of five (42.1%) graduates of master's degree professional programs never attended meetings.

Attendance at Local Meetings

Local meetings were not very well attended, although participation was better than for national meetings. Nearly two-thirds (63.8%) of active members seldom or never attended a chapter, district, or section meeting. Conversely, 15.7 percent of the respondents indicated that they attended all or most of these meetings.

When analyzed in additional detail, the attendance pattern at local meetings was similar to the pattern noted at national meetings. Men, academicians, and sole owners or partners in physical therapy practices were the most likely to attend local meetings. The one exception noted occurred when respondents were categorized based on professional program completed. Graduates of postbaccalaureate certificate programs were the most likely group to attend local meetings. However, graduates of baccalaureate degree programs were slightly more likely to attend local meetings in comparison to graduates of master's degree programs. These results were very similar to those of respondents to the 1990 Profile.



Participation and Service

Similar to 1990 results, less than one of ten respondents participated in any of the activities cited on the survey instrument. The activity in which active members participated most often was serving as a delegate. However, even this role was filled by a very small percentage (7.7%) of the membership. A slightly smaller percentage (6.6%) of the active members indicated that they had spoken at a business meeting. Even smaller percentages had made a motion at a business meeting or had held an appointed position in the Association. It was extremely rare for a respondent to indicate that he or she had served as chairperson of a committee or task force or had held an elected position as an officer.

Participation or Service at National Level

Activity	1990 %	1993 %
Served as a delegate	7.3	7.7
Spoke at a business meeting	6.0	6.6
Made a motion at a business meeting	4.5	3.9
Held an appointed position on a committee or task force	4.5	4.3
Served as chairperson of a committee or task force	1.9	2.2
Held an elected position as an officer	1.6	1.8

Participation in activities at the chapter or district level was more common place than at the national level. All the cited activities had much larger proportions of member participation at the local level. One-third of respondents (33.3%) had spoken at a local business meeting, and nearly as many respondents (25.6%) had made a motion at a business meeting or held an appointed position on a committee or task force (29.5%). Larger percentages of the active members had participated in the other local activities as well. The percentage of respondents participating in all local activities increased in comparison to 1990.

Participation or Service at Local Level

Activity	1990 %	1993 %
Held an appointed position on a committee or task force	27.7	29.5
Spoke at a business meeting	27.7	33.3
Made a motion at a business meeting	24.4	25.6
Served as chairperson of a committee or task force	18.9	19.3
Held an elected position as an officer	16.3	18.0
Served as a delegate	9.4	9.5

Because there were larger numbers of active members participating in activities at the local level as compared to the national level, further analyses were conducted on those activities. Generally, there was a relationship between the length of time a respondent had been an active member and participation in activities at a local level. Those members who had been practicing between 11 and 20 years were clearly the most active at the local level. When years of practice exceeded this interval, participation in local activities diminished.

Further, there were additional variables that were related to participation. Men, members from academic institutions and, to some extent, private practice settings, and those who had graduated from a postbaccalaureate certificate program were more likely to be active in chapter or district activities.

ATTITUDES TOWARD PROFESSIONAL ISSUES

The number of issues about which attitudes were solicited was increased by one in comparison to the 1990 survey. Issues relevant to many aspects of the profession were included. Those issues that elicited the most agreement had to do with licensure of the physical therapist assistant (PTA) and physical therapist involvement in physician-owned physical therapy services. More than four of five respondents (84.0%) either agreed or strongly agreed that the PTA should be licensed in all states. Nearly three-fourths of the active members (71.8%) believed that physical therapists should not be employed in physician-owned practices. This latter issue restates a position of the APTA.

A second initiative of the Association that was included dealt with patient treatment and evaluation through direct access. The Association has expended a great deal of time and resources to achieve direct access. Currently, 44 states permit evaluation via direct access, while 30 allow treatment via direct access. The membership clearly agrees with this initiative. More than two-thirds of respondents (67.1%) either agreed or strongly agreed with the statement that physical therapists should be able to evaluate and treat patients without referral.

There was not agreement, however, on all issues. Essentially the same proportion of active members believed that the Association should require continuing education for membership renewal as believed that continuing education should not be a condition for membership renewal. A similar distribution was found on the issue of the relationship between quality of care and the shortage of physical therapists. Although a substantial number of active members believed that the shortage of physical therapists was affecting quality care, there was also a substantial percentage of respondents who did not see a relationship between the shortage and the quality of care provided to patients. This latter distribution was interesting as the shortage of physical therapists has been viewed as a prominent issue by the Association. In fact, a conference devoted specifically to the theme of human resource issues was held in August, 1993. Based on survey responses, it appears that not all members are affected in the same way by the shortage.

Finally, some of the issues cited simply did not seem as important to respondents. For example, a substantial percentage of respondents (41.2%) had no opinion on the question of whether physical therapists should formally apply for clinical privileges. Responses to the question on the level of

professional degree also yielded some surprising results. The transition to a postbaccalaureate professional degree has been important to the Association since the late 1970s. However, even now, nearly half the respondents (45.5%) disagreed, or were neutral when asked if the postbaccalaureate degree should be the professional degree awarded to physical therapists.

Feedback from respondents to each of these items that characterize the membership's perspective on professional issues will be shared with Association leadership. The input from this portion of the survey will be used as input to the Association's planning process.

Inventory of Professional Issues

Issue	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5	No Opinion 9
	%	%	%	%	%	%
The postbaccalaureate degree should be the professional degree for physical therapists	12.0	14.5	19.0	23.3	27.1	4.1
Physical therapists should be able to evaluate and treat patients without referral	3.8	8.2	20.4	30.5	36.6	0.5
Physical therapists should not be employed in physician-owned practices	6.8	10.0	16.1	16.7	47.3	3.1
The shortage of physical therapists directly affects the care I currently provide to patients	19.0	16.9	15.7	18.2	27.1	3.1
Cost containment efforts (by Medicare and other insurers) directly affect my ability to provide clinical care	6.2	10.4	14.7	26.2	36.8	5.7
The physical therapist assistant should be licensed in all states	2.2	2.0	6.3	16.3	66.7	6.5
Physical therapists should formally apply for clinical privileges in hospitals	8.9	9.6	16.4	10.6	11.3	43.2
The American Physical Therapy Association should require continuing education for membership renewal	21.6	15.7	18.3	18.4	23.0	3.0
Continuing education should be a requirement for licensure	10.4	9.9	18.7	25.3	34.0	1.7
Physical therapists should collaborate with other health care professionals (e.g., occupational therapists, chiropractors, athletic trainers)	3.1	3.7	16.0	26.9	45.0	5.3
The shortage of physical therapists has resulted in encroachment by others into physical therapy practice	3.3	6.4	12.9	28.9	43.5	5.0

References

1. 1990 Active Membership Profile. Alexandria, VA: American Physical Therapy Association.

2. 1987 Active Membership Profile. Alexandria, VA: American Physical Therapy Association.

3. Goldstein, M.S. Professional Student Survey. Alexandria, VA: American Physical Therapy Association, 1991.

4. Professional Education Fact Sheet. Alexandria, VA: American Physical Therapy Association, 1990.

5. Task Force on Practice Privileges. Report to the APTA Board of Directors. Alexandria, VA: American Physical Therapy Association, 1991.

Appendix A

Introductory Letter

apta

American Physical
Therapy Association
1111 North Fairfax Street
Alexandria, VA 22314-1488
703/684-2782
703/684-7343 Fax

Officers

Marilyn Moffat, PT, PhD, FAPTA
President

Jane M. Walter, PT, EdD
Vice President

Barbara A. Melzer, PhD, PT
Secretary

David W. Perry, MS, PT
Treasurer

Andrew A. Guccione, PhD, PT
Speaker of the House

Ben F. Massey, Jr, PT
Vice Speaker

Directors

Samuel M. Brown, PT

Susan S. Deusinger, PhD, PT

Janet L. Gwyer, PhD, PT

Colleen M. Kigin, MPA, PT

Patricia C. Montgomery, PhD, PT

Roger M. Nelson, PhD, PT

Blair J. Packard, MS, PT

Jan K. Richardson, PT, PhD, OCS

Joseph W. Smey, EdD, PT

[illegible]

Francis J. Mallon, Esq

CPA•APTA•1994
JOINT CONGRESS
Toronto
June 4-8, 1994

April 26, 1993

Dear Active Member and Colleague:

You have been selected to help us generate the data needed for the 1993 Active Membership Profile. Information concerning you and your fellow physical therapists is vital in responding to requests from government agencies, external organizations, educational institutions, health care facilities, APTA chapters and sections and APTA members. The information will also help to guide the plans and work of our Board of Directors and committees.

The 1993 Active Membership Profile questionnaire enclosed with this letter provides a special opportunity for you to provide us with feedback and opinions on a variety of APTA policies, activities, and services. Your response will provide important information to be used for the study of the APTA's organizational structure, for evaluation of our strategic planning and for planning ways in which the APTA can better serve all of us.

The instructions for completing the questionnaire are printed on the reverse side of this letter. As you read the instructions and prepare to complete the questionnaire, please be assured that your answers to the questions will be absolutely confidential. To help guarantee this confidentiality, please do not write your name or address on the questionnaire or the return envelope.

The highest possible "return rate" is essential to assure the validity of the survey and to assure that the results are representative of all of our active members. Please complete the questionnaire and return it to the APTA before **MAY 27, 1993** in the self-addressed, postage-paid envelope. However, if you complete the questionnaire later than his date, please feel free to return it. Your cooperation is indeed appreciated, and assures that APTA will continue to be the primary source of information on physical therapy in the United States.

Sincerely yours,

Marilyn Moffat

Marilyn Moffat, P.T., Ph.D., FAPTA
President

Marc Goldstein, Ed.D.
Director, Research Services

Enclosure: 1993 Active Membership Profile Questionnaire

****Please turn over for instructions on completing the questionnaire****

AMERICAN PHYSICAL THERAPY ASSOCIATION
1993 ACTIVE MEMBERSHIP PROFILE SURVEY

INSTRUCTIONS

PLEASE READ THESE INSTRUCTIONS BEFORE COMPLETING THE ENCLOSED QUESTIONNAIRE

Completing the enclosed questionnaire for the APTA 1993 Active Membership Profile Survey will take less than 30 minutes of your time.

Choosing Numbered Answers

Most of the questions pose numbered answers from which are to select your answer by marking a circle around the number of the one answer of your choice, for example:

01. Please indicate your gender:

1 Female **2** Male

Several questions permit choosing more than one answer. Each of these questions, on which you may choose one or more answers, includes specific instructions, for example:

30. How would you describe the type(s) of facility(ies) or institution(s) in which (or for which) you work in a typical working week? (Please circle any and all that apply.)

1 Hospital **3** Private Physical Therapy Office

2 Home Health Agency **4** Other

Please do not write answers to the questions that have numbered answers.

Writing in numbers as answers

Other questions are to be answered by writing numbers in "boxes" provided for that purpose. Please write no more than one digit in a box, for example:

02. Please state your age in years (at nearest birthday):

[__|__]

PLEASE DO NOT WRITE YOUR NAME OR ANY OTHER IDENTIFYING INFORMATION ON YOUR QUESTIONNAIRE. AFTER YOU HAVE COMPLETED THE QUESTIONNAIRE, PLEASE TAKE A FEW MINUTES TO MAKE CERTAIN THAT YOU HAVE ANSWERED ALL APPROPRIATE QUESTIONS, THEN RETURN THE QUESTIONNAIRE TO APTA IN THE ENCLOSED SELF-ADDRESSED, POSTAGE-PAID ENVELOPE.

Thank you for your time and assistance on this survey and for returning the completed survey before MAY 27, 1993

Appendix B

1993 Active Membership Profile Survey

AMERICAN PHYSICAL THERAPY ASSOCIATION

1993 ACTIVE MEMBERSHIP PROFILE SURVEY

BIOGRAPHIC INVENTORY

01. Please indicate your gender:

1 Female 2 Male

02. Please state your age in years (at last birthday):

[___|___] years

03. Which one of the following best describes your race or ethnic origin?

1 American Indian or Alaskan Native
2 Black (not of Hispanic origin)
3 White (not of Hispanic origin)
4 Asian or Pacific Islander
5 Hispanic
6 Other

04. How many years have you been a physical therapist? **(Please write [0|0] if less than one year.)**

[___|___] years

05. How many years have you been in your current position? **(Please write [0|0] if less than one year.)**

[___|___] years

06. How many different positions have you had since you have been a physical therapist?

[___|___] positions

07. Please state the five-digit zip code of the location at which you received this questionnaire in the mail (if you wish, the first 3 digits will do.)

Zip [___|___|___|___|___]

08. Please state the five-digit zip code of the location of your current (primary) place of employment (if you wish, the first 3 digits will do.)

Zip [___|___|___|___|___]

09. In how many different states do you currently maintain a license to practice physical therapy? **(Please write [0|0] if you do not currently maintain a license in any state.)**

[___|___] states

1992 EMPLOYMENT INVENTORY

10. Were you employed or self-employed (whether full-time or part-time) throughout the full calendar year in 1992?

1 Yes 2 No **[Go to Question 14]**

11. Which one of the following best describes what your employment status was throughout the full calendar year in 1992? **(Please use 35 or more hours per week as the definition of full-time employment status.)**

1 Full-time salaried **3** Part-time salaried

2 Full-time self-employed **4** Part-time self-employed

12. Please state your gross earned income for the full calendar year in 1992:

$ [___|___|___|,|___|___|___|.|___|___]

13. Please state the total amount of your personal business and professional expenses, if any, for the full calendar year in 1992:

$ [___|___|___|,|___|___|___|.|___|___]

14. Has your career ever been interrupted since you became a physical therapist?

1 Yes 2 No **[Go to Question 17]**

15. How many times has your career been interrupted since you became a physical therapist?

[___|___] number of times

16. Which of the following describes the reason(s) for your career interruption? (**Circle all that apply**)

1 Time to raise a child

2 Worked in another career field

3 Returned to school

4 Relocated due to spouse's change of employment

5 Other; please specify _____

CURRENT PROFESSIONAL INVENTORY

17. Which one of the following best describes your current (1993) employment status? (**Please use 35 or more hours per week as the definition of full-time employment status.**)

1 Full-time salaried **[Go To Question 18]**

2 Part-time salaried **[Go To Question 18]**

3 Full-time self-employed **[Go To Question 18]**

4 Part-time self-employed **[Go To Question 18]**

5 Retired **[Go to Question 38]**

6 Unemployed (not retired) **[Go to Question 38]**

18. Which one of the following best describes your current (**primary**) position? (**Circle all that apply**)

1 Sole owner of physical therapy practice or business

2 Clinical administrator or director of physical therapy

3 Clinical supervisor or coordinator of physical therapy

4 Staff physical therapist

5 Senior staff physical therapist

6 Partner in physical therapy practice or business

7 Academic administrator or director of physical therapy education program

8 Academic faculty member

9 Other; please specify _____

19. Indicate which of the following best describes the type of facility or institution in which (or for which) you perform all or most of your responsibilities. **(Circle one only.)**

1 Hospital

2 Home health agency

3 Rehabilitation center (in-patient and out-patient)

4 Extended care facility/nursing home

5 Academic institution

6 Research center

7 Private physical therapy office

8 Physician's office

9 Rehabilitation center (out-patient only)

10 Public or non-public school (K-12)

11 Prepaid health care organization

12 Other; please specify _____

20. Indicate which of the following describes the type of facility(ies) or institution(s) in addition to the one specified in question 17 in which (or for which) you are also employed. **(Circle all that apply)**

1 I work at no other setting in addition to my full-time position

2 Hospital

3 Home health agency

4 Rehabilitation center (in-patient and out-patient)

5 Extended care facility/nursing home

6 Research center

7 Private physical therapy office

8 Physician's office

9 Rehabilitation center (out-patient only)

10 Public or non-public school (K-12)

11 Prepaid health care organization

12 Academic institution

13 Other; please specify _____

21. Please indicate the source of your salary for your current primary position:

1 Salary paid by the entity where you do all or most of your work

2 Salary paid by a private physical therapy practice

3 Salary paid by an entity other than above; please specify _____

22. Do you currently and personally see (evaluate, treat, instruct) patients in a typical working day?

1 Yes 2 No **[Go to Question 32]**

23. Do you provide services specified under contractual agreement(s) to an institution other than your own?

1 Yes 2 No 3 Not Applicable

24. Do you currently practice in a physician-owned physical therapy practice?

1 Yes 3 Not Applicable

25. Do you currently and personally direct and supervise the performance of selected physical therapy procedures and related tasks by one or more physical therapist assistants?

1 Yes 2 No 3 Not Applicable

26. Do you personally direct and supervise the performance of selected physical therapy tasks by one or more supportive personnel?

1 Yes 2 No **[Go to Question 27]** 3 Not Applicable **[Go to Question 27]**

26a. What types of supportive personnel do you supervise? **(Circle all that apply and indicate the number.)**

	Number		Number
1 On the job trained PT aides	[__|__]	4 Kinesiotherapists	[__|__]
2 Certified athletic trainers	[__|__]	5 Massage therapists	[__|__]
3 Exercise physiologists	[__|__]	6 Other, please specify and provide the number _____	[__|__]

27. What percentage of your practice time do you personally spend (evaluate, treat, instruct) with the following patient population age group(s)? **(Please check to see that the figures add up to 100 percent, even if you are employed or self-employed part-time; for each group, include time spent on related tasks such as preparation, record-keeping or documentation, etc.)**

Age Group	Percent Time/Week
1 Infants (less than 1 year)	[__|__]
2 Toddlers (1-3 years of age)	[__|__]
3 Children (4-12 years of age)	[__|__]
4 Adolescents (13-17 years of age)	[__|__]
5 Adults (18-64 years of age)	[__|__]
6 Older persons (65 years and older)	[__|__]
	100%

28. Identify the specialty area in which you focus your practice. **(Please circle only one.)**

1 Administration	5 Neurology	9 Pediatrics	13 No focus in any one area
2 Burn/wound care	6 Oncology	10 Sports	
3 Cardiac	7 Orthopaedics	11 Rehabilitation	
4 Education	8 Pulmonary	12 Other _____	

29. Please state the number of patient visits for which you personally provide direct care (evaluation, treatment, instruction) in a typical day:

Kinds of Patient Visits	Number of Visits/Day
1 In-patient visits	[__|__]
2 Out-patient visits	[__|__]
3 Home-bound patient visits	[__|__]
4 Total number of patient visits	[__|__]

30. Do you currently perform patient evaluation through direct access (without requiring referral from another practitioner)?

1 Yes 2 No 3 NA

31. Do you currently perform patient treatment through direct access (without requiring referral from another practitioner)?

1 Yes 2 No 3 NA

32. Please state the total number of hours in a typical week that you devote to your practice and practice-related responsibilities:

Include, if appropriate, time spent at home on practice-related responsibilities, and travel time required to provide home care.

Do **not** include time required to commute to and from place of employment, and volunteer time devoted to Association, Chapter, District, or Section duties.

_____ hours

33. What percentage of your practice time, in a typical week, do you devote to each of the following activities and responsibilities? **(Please check to see that the figures add up to 100 percent, even if you are employed or self-employed part-time; for each activity or responsibility, include time spent on related tasks such as preparation, record-keeping or documentation, etc.)**

Activity or Responsibility	**Percent Time/Week**
1 Direct patient care	[__|__|__]
2 Administration & management	[__|__|__]
3 Supervision & coordination of treatment	[__|__|__]
4 Teaching	[__|__|__]
5 Consultation	[__|__|__]
6 Screening & prevention	[__|__|__]
7 Research	[__|__|__]
8 Working with students	[__|__|__]
9 Other, please specify _____	[__|__|__]
	100%

34. Have you formally applied for clinical privileges in a hospital or similar setting?

1 Yes **2** No **[Go To Question 37]**

35. Did you obtain clinical privileges?

1 Yes **2** No **[Go To Question 37]**

36. Do you currently hold clinical privileges?

1 Yes **2** No

37. Which of the following best describe(s) your current, practice-related involvement in research? **(please circle all that apply, but do not include research that is required for a degree you expect to earn.)**

1 Design, conduct and report research

2 Read and discuss reports of research

3 Other involvement in research; Please specify _____

4 No involvement in research

38. What type of entry-level education program did you complete to become a physical therapist?

1 Baccalaureate degree

2 Master's degree

3 Postbaccalaureate certificate

4 Other, please specify _____

39. What was your age in years when you completed your education to qualify as a physical therapist?

[___|___] years

40. Did your entrance into the profession of physical therapy represent a change in profession or occupation?

1 Yes **2** No

41. What is the highest academic degree you hold in any area of study?

1 No academic degree **3** Bachelor's degree **5** Doctoral degree

2 Associate degree **4** Master's degree **6** Other, please specify _____

42. Are you currently enrolled in a post-professional graduate program (or in one or more courses for academic credit) to meet the requirements for a post-professional degree?

1 Yes, doctoral 2 Yes, master's 3 No

43. Are you currently enrolled in a postdoctoral program?

1 Yes 2 No

44. How many continuing education courses (not including courses for academic credit or in-service education) did you complete during the calendar year 1992?

[___|___] courses

45. How many professional and scientific books did you purchase for your own use during the calendar year 1992?

[___|___] books

46. How many scientific meetings other than those listed in question 44 did you attend during the calendar year 1992?

[___|___] meetings

47. Please state the number of professional and scientific journals, including Physical Therapy, to which you now subscribe:

[___|___] journals

48. Do you have sufficient working knowledge of research design and methods of statistical analysis to permit you to critically read and evaluate reports of research published in Physical Therapy and other professional and scientific journals?

1 Yes 2 No 3 Don't know

49. Do your personal plans for further professional development include preparing for and achieving formal certification as a specialist in a physical therapy specialty area?

1 Yes **2** No

↓

50. In which one of the following physical therapy specialty areas do you plan to achieve formal certification as a specialist? (**Circle all that apply**)

1 Cardiopulmonary

2 Neurologic

3 Pediatric

4 Geriatrics

5 Clinical Electrophysiologic

6 Orthopaedic

7 Sports Physical Therapy

ASSOCIATION INVENTORY

51. How many years has it been since you first became an Active Member of APTA? (**Please round off to the nearest whole number of years, and write [01] if one year or less.**)

[___|___] years

52. Does your employer reimburse for APTA dues?

1 No **2** Yes, partial **3** Yes, full

53. How regularly do you attend national meetings?

1 Attend all or most of the time

2 Attend half of the time

3 Seldom attend

4 Never attend

54. How regularly do you attend Chapter, District, or Section meetings?

1 Attend all or most of the time

2 Attend half of the time

3 Seldom attend

4 Never attend

INVENTORY OF PROFESSIONAL ISSUES

The American Physical Therapy Association would like your opinion about the following issues. On the following scale of 1 through 5, where **1** is **Strongly Disagree** and **5** is **Strongly Agree**, please indicate your agreement with the following statements. Please circle (9) if you do not have enough information on which to base an opinion.

	Strongly Disagree				Strongly Agree	No Opinion
61. The postbaccalaureate degree should be the entry-level degree for physical therapists	1	2	3	4	5	9
62. Physical therapists should be able to evaluate and treat patients without referral	1	2	3	4	5	9
63. Physical therapists should not be employed in physician-owned practices	1	2	3	4	5	9
64. The shortage of physical therapists directly affects the care I currently provide to patients	1	2	3	4	5	9
65. Managed care directly affects my ability to provide clinical care	1	2	3	4	5	9
66. The physical therapist assistant should be licensed in all states	1	2	3	4	5	9
67. Physical therapists should formally apply for clinical privileges in hospitals	1	2	3	4	5	9
68. The American Physical Therapy Association should require continuing education for membership renewal	1	2	3	4	5	9
69. Continuing education should be a requirement for re-licensure	1	2	3	4	5	9
70. Physical therapists should collaborate with other health care professionals (e.g., occupational therapists, physicians, athletic trainers)	1	2	3	4	5	9
71. The shortage of physical therapists has resulted in an increase in encroachment by others into physical therapy practice	1	2	3	4	5	9

THANK YOU FOR COMPLETING THE QUESTIONNAIRE.
PLEASE USE THE ENCLOSED POSTAGE-PAID ENVELOPE
TO RETURN THE QUESTIONNAIRE BEFORE MAY 27, 1993

Did you ever do the following at the National, Chapter, District, or Section level of the APTA? **(Please circle 1 Yes, 2 No or 3 NA for Questions 54 through 59.)**

	National			Chapter/District/Section		
	1 Yes	2 No	3 NA	1 Yes	2 No	3 NA
55. Spoke at a business meeting	1	2	3	1	2	3
56. Made a motion at a business meeting	1	2	3	1	2	3
57. Held an appointed position on a committee or task force	1	2	3	1	2	3
58. Served as chairperson of a committee or task force	1	2	3	1	2	3
59. Held an elected position as an officer	1	2	3	1	2	3
60. Served as a delegate	1	2	3	1	2	3